Florida KidCare Eligibility Determination Study
Findings and Recommendations

Prepared for the Florida Healthy Kids Corporation by MAXIMUS, Inc.

I. Executive Summary

Florida KidCare, which is Florida's comprehensive response to the needs of children who lack health insurance, is one of the largest programs of its kind in the country. KidCare consists of children's Medicaid and three state-designed programs that receive funding through Title XXI of the Social Security Act (also known as the Children's Health Insurance Program or "SCHIP"). The three non-Medicaid Title XXI programs are Healthy Kids, MediKids, and the Children's Medical Services Network (CMSN).

Since the adoption of the Florida KidCare Act in 1998, the entities responsible for administering the programs have made significant progress in how applications are received and screened, eligibility is determined, and children are enrolled in health plans or provider networks. Consumer surveys show that these efforts have had desirable results, with general program satisfaction remaining at a consistently high level. For example, the latest Annual KidCare Evaluation reports that over 95% of applicant families are satisfied with the mail-in application process.

In a demonstration of its commitment to ongoing quality improvement, the Florida Healthy Kids Corporation asked MAXIMUS, Inc. to study the KidCare eligibility determination processes to identify further opportunities for improved customer satisfaction. MAXIMUS analyzed the KidCare eligibility determination business processes within the context of three primary consumer-oriented goals and within the boundaries of existing state and federal law:

- *Reduce the time it takes to process an application and enroll an eligible child ("Timeliness").* This goal is directly related to the amount of time it takes for an eligible child's coverage to begin. While all KidCare programs fall comfortably below the federal goal that an eligibility determination is made within 45 days of an application's receipt, and the timeliness of the application process has demonstrably improved over the past several years, there are additional opportunities for even better performance.
- *Facilitate enrollment in the right program ("Program Fit").* This goal has to do with both program integrity (accurately evaluating a family's situation in light of the various eligibility criteria among the KidCare programs) and ensuring that the differing eligibility determination processes across the programs do not confuse or intimidate applicants.
- *Reduce the chances of a break in coverage for a child who is moving from Medicaid to a non-Medicaid Title XXI program ("Gap in Coverage").* Under the current processes, it is very likely that a child moving off of Medicaid as the result of a periodic re-determination will lose coverage for one or two months. One of

the most common themes in the interviews with all KidCare partners and stakeholders was the need for a more reliable and timely strategy.

In addition to these major goals, we also identified other opportunities for a better consumer experience in operational areas that are not directly related to the eligibility determination process.

Each of the following recommendations has the potential of improving the satisfaction level of KidCare applicants or enrollees, either directly or indirectly through a more efficient and transparent process. Some of the recommendations will have a financial impact, either through short-term implementation costs or long-term operational effects. Others will be result in cost savings through the reduction of unnecessary or duplicative work and more efficient deployment of automated resources. We acknowledge that one or more KidCare partners may not support some of the recommendations, even though we considered their feedback and perspective in drafting the report. When we made a recommendation that we knew would not enjoy unanimous support, we did so out of a conviction that the proposed change would be operationally feasible and result in a more positive consumer experience.

The recommendations refer to various KidCare partners and contractors. A full description of these entities can be found in Section III(A) of the report.

A. Opportunities that can be Implemented Immediately

Recommendation #1: Change the Medicaid Screen to Count Social Security Income. The screening algorithm Dental Health Administrative and Consulting Services (DHACS) uses to refer children potentially eligible for Medicaid should be changed to count, rather than disregard, Social Security income. This change should eliminate more than half of the "false positive" referrals to the Department of Children and Families (DCF) that are denied and sent back to DHACS for Title XXI processing, lessening the time it takes to process those applications and eliminating unnecessary work at DCF.

Recommendation #2: Do Not Make the State Employee Match a Pre-Condition of Eligibility. The monthly data matching process that is used to identify children who are the dependents of state employees (and are therefore ineligible for Title XXI benefits) should only have the effect of a program integrity strategy designed to meet federal law. It should not be a roadblock to a timely eligibility determination. This change will reduce the time it takes to process a completed application, in some cases by almost a month.

Recommendation #3: Add Health Status and Immigration Information to the Passive Renewal Notice. Just as the KidCare application gives families the chance to identify children with special health care needs, we believe the passive renewal process should do that as well. The renewal form should also be modified to solicit updated immigration documentation from families with a non-qualified non-citizen child. Providing an additional and recurring means of ensuring that children with special health care needs are identified will be beneficial since CMSN is specifically designed to meet the unique needs of those children. Requesting updated immigration documentation from certain immigrant

families will ensure that children who are newly eligible for Medicaid or the Title XXI subsidy will not be denied or placed on waiting lists.

Recommendation #4: Maintain the Title XXI Continuous Eligibility Period for Families that Self-Report Changes in Income or Household Size. While the federal SCHIP law requires states to screen new applicants and renewing members for potential Medicaid eligibility, this requirement does not extend to a change in family status that occurs during the six-month continuous eligibility period mandated under the Florida KidCare Act. Maintaining six months of continuous eligibility for families that experience a downward change in income will promote continuity of care.

Recommendation #5: Electronically Transmit the MediKids Provider Choice File on a Weekly Basis and Permit New Enrollees to be Added to the Supplemental File. Under the current environment, MediKids provider choices are to DHACS only two or three times a month. In addition, children who are found to be eligible for MediKids in the latter half of the month must wait an additional month for coverage because the MediKids supplemental file does not accept new enrollees. Adoption of this recommendation will enable some children to begin coverage in MediKids a month earlier, including children who are moving from Medicaid to MediKids.

Recommendation #6: Electronically Transmit All Available Sibling Information to DCF. To aid in the timely processing of children referred to DCF, all available sibling information should be included in the referral file so that DCF staff can more accurately determine the number of family-members living within the household. This should speed the processing of any application that includes siblings who are not referred to DCF and should prevent DCF from having to request information that was previously provided on an application.

B. Short-Term Opportunities (changes that can be implemented in six to eight months)

Recommendation #7: Mitigate the Impact of the Current Monthly Medicaid Match Strategy. The eligibility determination process should be changed to incorporate a "real-time" or similarly expeditious means of identifying applicant children who are currently enrolled in Medicaid rather than relying on a once-a-month approach that impedes the timely disposition of completed applications. Removing this impediment will reduce the time it takes to process an application, in some cases by almost a month.

Recommendation #8: Implement an Automated Referral Process for Children Leaving Medicaid. An electronic file exchange between DCF and DHACS should be deployed to facilitate the transition of children leaving Medicaid to enroll in Healthy Kids, MediKids, or Title XXI CMS. An automated alternative to the current paper-based method will be faster, more efficient, and more reliable.

Recommendation #9: Solicit Missing Information by Phone. A third of all applications arrive at DHACS lacking information that is needed to determine a child's eligibility for Medicaid or Title XXI. Prior to sending a missing information letter, a KidCare

representative should try to collect the data by phone. When a family is successfully reached by phone, the application will finish processing sooner.

Recommendation #10: Re-engineer the CMSN eligibility determination process. When a child is referred to the CMSN program for health status screening, a clinician applies a multi-tiered screening tool. CMSN executive staff prefers an alternative approach that could take less time and effort and be less susceptible to individual clinical interpretation. Accordingly, we propose that the KidCare application's child-specific health status question be eliminated in favor of a multi-question test that is applied at the family level to all applicant children.

Recommendation #11: Improve the Automated Link between CMSN and DHACS. A Medicaid referral disposition flag should be added to the interface between the DHACS and CMSN systems. This system change will improve the chances that a child who qualifies for Medicaid and CMSN will not mistakenly enroll in MediPass or a Medicaid HMO

Recommendation #12: Make the Child Social Security Number (SSN) a Required Data Element. A recent change in federal rules gives states this option. If Florida takes advantage of this opportunity, this change will expedite the processing of a Medicaid referral and increase the reliability and feasibility of the automated data interfaces proposed in Recommendations #7 and #8.

Recommendation #13(a): Application Change---Collect Information for Non-Applicant Children. The current application does not adequately account for the differences in how Medicaid and Title XXI calculate family size. To address this, an additional question should be added to the application for each non-applicant child living in the household to collect the child's name, birth date, and relationship to the parent(s) or guardian(s). Collecting this information at the time of the original application will speed the processing of certain Medicaid referrals and improve the accuracy of the Medicaid screening process

Recommendation #13(b): Application Change---Request Immigration Documentation at the Time of Application. Because families of non-citizen applicant children will have to produce the necessary written material anyway, requesting it at the time the application is submitted will save time and be less confusing for the family. This request should be noted on the application with additional information in the accompanying brochure.

Recommendation #14: DHACS Review of Immigration Documentation Should Be Accepted for Medicaid Review Purposes. If DHACS reviews the immigration documentation of non-citizen children prior to their referral to DCF---which will be a consequence of Recommendation #13(b)---then a subsequent review at DCF will be costly in terms of time and workload. DCF acceptance of DHACS immigration documentation reviews will speed the handling of Medicaid referrals and prevent duplication of effort.

Recommendation #15: Implement a Statewide Online KidCare Application. An online KidCare application should be deployed statewide to permit electronic entry of application information, generation of a tentative eligibility determination, and submission of

electronic data or production of a written application at the family's printer. A well-designed, secure, and robust online application will reduce the time it takes to turn application information into useable electronic data and lessen the likelihood of critical missing data elements as well as provide an additional point of access.

Recommendation #16: Handle all KidCare Referrals at the Central Processing Units. For reasons of efficiency and timeliness, DCF should handle KidCare referrals involving open cases in FLORIDA within the appropriate CPU rather than routing them to local Public Assistance Specialists. To implement this recommendation, a DCF workgroup should be formed to address applicable security and business process issues.

C. Long-Term Opportunities

Recommendation #17: Create an Automated Data Interface Between the DCF Eligibility System (FLORIDA) and the Third Party Administrator's System (CHAS). A well-designed and secure online interface will speed up processing times, eliminate duplication of effort, facilitate the timely transfer of data for children who are moving between programs, and provide for a common understanding regarding the business rules governing each KidCare program.

Recommendation #18: Permit the Third Party Administrator to Make Medicaid Determinations. The Florida KidCare Title XXI State Plan Amendment should be changed to allow the FHKC third party administrator to make definitive Medicaid eligibility determinations subject to a *pro forma* DCF approval. This will speed up the process for any child who is currently affected by the DCF referral processes, eliminate "false positive" referrals to DCF, and create smoother transitions between all KidCare programs

Recommendation #19: The Medicaid Re-determination Process Should be Re-Engineered. A version of "passive renewal" approach used in Florida's non-Medicaid Title XXI programs is responsible for some of the highest retention SCHIP rates in the country and a high degree of consumer satisfaction. We believe a similarly user-friendly re-determination process should be extended to children who are receiving benefits through KidCare Medicaid. DCF can facilitate eligibility determinations for children leaving Medicaid by electronically sending to DHACS the data that CHAS needs to make a Title XXI determination or by giving Public Assistance Specialists the authority to make Title XXI determinations.

Recommendation #20: Process KidCare Applications in Florida. If DHACS locates an operation in Florida, perhaps for a call center or some other significant operational component, the scope of that operation should be expanded to include the opening, batching and scanning of applications. Physically processing applications in Florida rather than elsewhere will save a day's worth of processing time.

D. Other Recommendations Not Related to the Primary Goals

Recommendation #21: Adopt Virtual Private Network (VPN) Technology to Transfer Sensitive Client Information. VPNs are widely used in corporate and business

computing environments and are much more secure and reliable than the data exchange methods currently employed within the KidCare electronic infrastructure.

Recommendation #22: Align Medicaid and Title XXI Eligibility Rules. Family size, countable income, and income disregards for each KidCare program could be calculated using the Medicaid formulas to simplify the integration of the KidCare eligibility systems and reduce the likelihood of consumer confusion.

Recommendation #23: Additional Application Changes. When the next Application Workgroup is convened, we recommend several additional changes to the application and informational brochure to address immigrant concerns about the "public charge" issue, provide a context for why certain information is solicited, and remind applicants of the difference between "Social Security" income and "SSI" income.

Recommendation #24: Change How the DHACS System Generates Correspondence. CHAS should be re-programmed to reduce or eliminate multiple missing information letters going out to the same family and prevent the erroneous solicitation of immigration documentation when it has already been submitted.

Recommendation #25: Investigate the Feasibility of Synchronizing the Monthly Processing Schedules for MediKids and Healthy Kids/CMSN. Different cut-off dates for MediKids and Healthy Kids/CMSN means that, under certain circumstances, a younger child eligible for MediKids will have to wait an additional month for coverage to start compared to the siblings who qualify for Healthy Kids and/or CMSN. This not only means an additional month of risk for the younger child, it also means a decoupling of the six-month continuous eligibility period among the children within a family, which will complicate the renewal process. Several of the KidCare partners individually suggested uniform monthly and supplemental processing dates for the non-Medicaid Title XXI programs. This is a goal worth pursuing.

Recommendation #26: Establish a Data Link between the CMSN and DCF eligibility systems. Because CMSN is a provider network for Medicaid as well as Title XXI, the lack of an electronic interface with DCF makes it difficult for CMSN to identify and track children enrolled in Medicaid who have long-term chronic conditions or disabilities and work with their families to ensure that they receive their benefits through CMSN rather than a Medicaid HMO or MediPass. This interface, which would function in a manner similar to the interface between DHACS and CMSN, would address that problem.

Recommendation #27: Evaluate Optical Character Recognition (OCR) for Data Entry. The layout of the KidCare application, in which parent and child information is captured letter-by-letter in individual boxes, is well suited for reading by Optical Character Recognition (software). When it works well, OCR software is a significant improvement over manual data entry. When it works poorly, it is counter-productive because the data still has to be manually proofed and corrected as needed. A workgroup comprised of DHACS and FHKC staff should objectively evaluate the relative benefits and risks of moving to an OCR approach for entry of data captured on the first page of the application.

Recommendation #28: More Systematic Communication Among the KidCare Partners. The KidCare partners should agree on a systematic, routine, and timely communications protocol involving relevant leadership and staff so that major policy changes and communication initiatives occur with the understanding of all the key players. This does not necessarily mean unanimous consent regarding all major issues or initiatives. Rather, when disagreements occur, the results should be healthier and more productive if they take place within an environment of open and systematic communication.

II. Overview

A. Highlights of Florida KidCare

With the release of its most recent Annual Evaluation report, Florida KidCare celebrated and documented a remarkable public health achievement: almost one and a quarter million previously uninsured Florida children enrolled and receiving health benefits through one of the KidCare programs at the end of September, 2001, which is a 15% cumulative increase in enrollment over 12 months. Twenty percent of these children received their coverage through Title XXI (also known as the State Children's Health Insurance Program or SCHIP), almost 80 percent were covered by Title XIX Medicaid, and a small percentage were covered by the Florida Healthy Kids Program at full cost to the family.

The concept from which Healthy Kids evolved was articulated in a 1988 article authored by Dr. Steve Freedman that appeared in the New England Journal of Medicine. This article, entitled "Coverage of the uninsured and underinsured: A proposal for school enrollment-based family health insurance," proposed grouping school children together in order to purchase health coverage at reasonable rates. These groupings were intended to resemble and carry the same pricing advantages as employer groups.

In 1990, the Florida Legislature enacted the Florida Healthy Kids Corporation Act, which statutorily created the non-profit Florida Healthy Kids Corporation. The initial Florida Healthy Kids pilot site was implemented in Volusia County in 1992, through several avenues including a Medicaid 1115 waiver, state funding, and Robert Wood Johnson Foundation financial assistance.

Shortly after Congress enacted Title XXI of the Social Security Act in 1997, Florida submitted its initial state plan, which expanded the existing Healthy Kids program and expanded Medicaid eligibility for children ages 15-19. In 1998, the Florida Legislature

adopted the Florida KidCare Act. This groundbreaking legislation dramatically expanded access to affordable children's health insurance by creating an operational umbrella for the following independent but related health insurance programs:

- **Children's Medical Services Network (CMSN)**, a state-run provider network for children with special health care needs who also qualify for Title XIX or Title XXI coverage. In effect, CMSN is the health plan for children who meet the eligibility guidelines for Title XXI and would otherwise enroll in MediKids or Healthy Kids but for their health status. Similarly, a special needs child who is a Medicaid recipient has CMSN as a health plan choice. CMSN was created to offer a continuum of care to special-needs children, including early intervention programs, primary and specialty care, long-term care, and case management. A subset of children who have behavioral needs receive services through the Behavioral Health Network. The Florida Department of Health is the KidCare partner that administers CMSN.

- **Healthy Kids**, a program that is modeled on commercial health insurance, targeted to children ages 5 through 18. Most children enrolled in Healthy Kids have their coverage subsidized through Title XXI and their families pay a $15 monthly premium. Healthy Kids families who don't meet the income requirements associated with the subsidy pay monthly premiums that range between $83 and $153 per child. General and specialized health services are available through commercial HMOs and an Exclusive Provider Organization (EPO) and comprehensive dental coverage is currently being phased in. Title XXI matching funds primarily come from the state, although local governments also contribute. The Florida Healthy Kids Corporation (FHKC), a non-profit non-governmental entity, is the KidCare partner that runs the Healthy Kids program.

- **Medicaid**, the longstanding comprehensive medical program for low-income families, is part of the KidCare program insofar as it pertains to children under the age of 19. Most children covered by Medicaid are funded through Title XIX, while a relatively small percentage are funded through Medicaid expansions authorized under Title XXI. Families whose children are enrolled in Medicaid pay nothing for these services. The Department of Children and Families (DCF), another KidCare partner, determines eligibility for Medicaid while program administration is carried out by the Agency for Health Care Administration (AHCA). DCF also screens children with behavioral needs for the Behavioral Health Network.

- **MediKids**, a Medicaid "look-alike" program for children between their first and fifth birthdays. MediKids, which is exclusively funded through Title XXI, offers the same benefits package as Medicaid except for certain special waiver services. There is one key operational distinction from Medicaid: MediKids covers health care costs prospectively rather than for three retroactive months. Children enrolled in MediKids receive their care through Health Maintenance Organizations (HMOs) in counties where at least two Medicaid HMOs are available. In counties

with only one Medicaid HMO choice, the MediPass Primary Care Case Management (PCCM) provider network is also available. The KidCare partner responsible for MediKids is AHCA.

Eligibility for the KidCare programs---except for Healthy Kids under the full-pay option---is based on a family's income as a percentage of the federal poverty level (FPL) and several other criteria. Medicaid is an entitlement, meaning any qualified child may receive benefits regardless of budget constraints. Conversely, the Title XXI non-Medicaid programs have the authority to establish waiting lists to manage program budgets as needed. Families enrolled in the three Title XXI non-Medicaid programs (including CMSN) pay $15 per month for all enrolled children and eligibility is continuous over six-month increments. While eligibility for Title XXI CMSN on the basis of health status lasts for 12 months, actual coverage is subject to the 6-month intervals. Medicaid eligibility is continuous over 6 or 12 month periods, depending on a child's age.

Like virtually every other state, the income criteria for the various KidCare programs are "stair-stepped" based on a child's age and family income:

- Medicaid is available to: babies up to age 1 from families with incomes at or below 200% FPL; 1-5 year-olds at or below 133% FPL; and 6-18 year-olds at or below 100% FPL
- MediKids is available to children ages 1 through 4 from families with incomes above 133% and at or below 200% FPL
- Healthy Kids (subsidized through Title XXI) is available to children ages 5-18 from families with incomes at or below 200% FPL and who are otherwise ineligible for Medicaid

As noted above, CMSN is a provider network, which means eligibility for CMSN overlaps the criteria for Medicaid, MediKids and Healthy Kids. Possible eligibility for CMSN is identified through a question on the application that is related to a child's health status.

Medicaid does not calculate a family's income as a percentage of FPL in the same way as the non-Medicaid programs. Dsregarding certain types of income and limiting family size to children and parents is how Medicaid eligibility is calculated (including Title XIX CMSN). Conversely, MediKids, Healthy Kids, and Title XXI CMSN count all income and all persons living within a household.

In addition to the income criteria, children eligible for Title XIX and Title XXI programs must be U.S. citizens or non-citizens who meet particular immigration documentation requirements. To qualify for Title XXI, a child must also be uninsured, not be the dependent of a person who receives insurance benefits from a state agency, and not be an inmate of a public institution or a patient in an institution for mental disease.

One of the factors that links the four KidCare programs is a mail-in application that serves Title XXI needs and is approved by DCF for Medicaid purposes (making it a "joint"

application). No face-to-face interviews are required and most of the information on the application, including income data, is self-attested with no additional verification requirements.

The joint application allows a parent or guardian to gain access to quality health benefits for an uninsured child without needing to know about the different eligibility criteria that exist among the four KidCare programs. The screening and referral processes are largely invisible to families, meaning that an eligible family can move from the application stage to enrollment to commencement of coverage through submission of a single application. The success of this approach is verified in the latest Annual KidCare Evaluation, which reports that over 95% of KidCare applicant families are satisfied with the mail-in application process.

B. The Study's Purpose and Goals

Every state that has implemented a state-designed SCHIP program has encountered challenges in efficiently and transparently screening children for Medicaid and Title XXI and ensuring that transitions between programs occur reliably and with minimal breaks in coverage. Similarly, because eligibility requirements for Medicaid and Title XXI programs are not identical and eligibility for Medicaid must be evaluated before Title XXI eligibility can be determined, there may be difficulties in ensuring that applications are processed in the shortest reasonable amount of time. These inherent challenges are magnified in Florida because there are four components to the state-designed Title XXI program, each with its own set of eligibility criteria, enrollment procedures, and agency oversight.

Since the adoption of the Florida KidCare Act four years ago, the KidCare partner agencies have made significant progress in receiving and screening applications, determining eligibility, and enrolling children. Specifically, these efforts have resulted in a transition of certain manual processes to automated ones, greater use of electronic approaches to storing, sending, and receiving application and enrollment information, and improvements in how applications are handled and reviewed. Some of these changes grew out of a 1999 MAXIMUS re-engineering study. Consumer surveys show that these efforts have had desirable results, with general program satisfaction remaining at a consistently high level.

Early in 2002, in a demonstration of its commitment to ongoing quality improvement, the Florida Healthy Kids Corporation asked MAXIMUS, Inc. to study the KidCare eligibility determination processes to identify further opportunities for improved customer satisfaction. This report contains the findings of that study and recommendations that can be implemented immediately or in the near or long-term future.

In approaching this study, MAXIMUS identified several goals that are shared by each of the individual KidCare programs:

- Accurately determine the eligibility of each applicant child
- Determine eligibility in the shortest period of time possible while maintaining program integrity

- Ensure that children move between programs without experiencing breaks in coverage or unnecessary bureaucracy

Failure to achieve these goals results in a number of tangible and undesirable outcomes:

- Unnecessarily long processing timeframes delay coverage for eligible children, frustrate applicants, and weaken the reputation of the programs among stakeholders and policy-makers
- Providers go unpaid and children fail to get needed acute and preventive care when transitions between programs break down

MAXIMUS agreed to study all of the eligibility determination business processes to identify ways of improving consumer satisfaction. Specifically, our efforts focused on the following goals that are directly linked to a better consumer experience and a more reliable approach to providing health coverage to uninsured children:

- *Reduce the time it takes to process an application and enroll an eligible child.* This goal is directly related to the amount of time it takes for an eligible child's coverage to begin. While all KidCare programs fall comfortably below the federal goal that an eligibility determination is made within 45 days of an application's receipt, and the timeliness of the application process has demonstrably improved over the past several years, we believe there are additional opportunities for even better performance.
- *Facilitate enrollment in the right program.* This goal has to do with both program integrity (accurately evaluating a family's situation in light of the various eligibility criteria among the KidCare programs) and ensuring that the differing eligibility determination processes across the programs do not confuse or intimidate applicants.
- *Reduce the chances of a break in coverage for a child who is moving from Medicaid to a non-Medicaid Title XXI program.* Under the current processes, it is very likely that a child moving off of Medicaid as the result of a periodic re-determination will lose coverage for one or two months. One of the most common themes in our interviews with all KidCare partners and stakeholders was the need for a more reliable and timely strategy.

In addition to these major goals, our study also uncovered other opportunities for quality improvement and an enhanced consumer experience that are not necessarily directly related to the eligibility determination process. These are included in Section VII at the end of the report.

C. The Study's Methodology

In addition to the Florida Healthy Kids Corporation, which is a private, non-profit corporation, the KidCare program unfolds across several state agencies: the Agency for Health Care Administration (AHCA), the Department of Children and Families (DCF), the

Florida Department of Health (DOH), and the Department of Banking and Finance. In addition, two private companies play a prominent role in the eligibility determination process: Dental Health Administrative and Consulting Services (DHACS) is a third party administrator under contract to FHKC and Affiliated Computer Systems (ACS) operates the Florida Medicaid Management Information System (FMMIS) under contract with AHCA.

Given the involvement of these various agencies and companies in critical aspects of the eligibility determination process, MAXIMUS adopted a study approach that was inclusive and comprehensive. The following are the highlights of the methodology that forms the foundation of this report:

- *Onsite interviews.* Interviews were held with key program and technical staff from FHKC, AHCA, DOH, DCF, and DHACS. The interviews were preceded by the development and dissemination of a set of customized interview tools. These tools ensured productive interviews with participants who were uniformly well prepared and responsive.
- *Review of relevant written reports.* To gain an understanding of the overall KidCare administrative structure as well as the program's history and consumer experience, MAXIMUS reviewed the Title XXI State Plan Amendment, the Annual Evaluation reports for the past three years and the most recent report of the KidCare Coordinating Council. We also reviewed other material found on the KidCare website, Healthy Kids website, and the website of the Institute for Child Health Policy (ICHP).
- *Written documentation.* To ensure a proper understanding of the current business processes, we asked each participating entity for relevant written documentation. Some examples of the material we received are form letter templates, process flow diagrams, processing volume reports, and screening tools.
- *Follow-up requests.* As the report began to take shape, we communicated with a variety of individuals via phone or e-mail to ensure that our comprehension of the business processes was accurate and consistent with the views of the participating agencies. We also requested several ad hoc database queries to validate specific assumptions.
- *Recommendations based on consensus.* While we believe the fundamental purpose of the study was to solicit objective and informed recommendations from a qualified third party, we also appreciate our obligation to make recommendations that are grounded in a realistic understanding of the program's operational dynamics. Therefore, the four KidCare agencies and the third party administrator under contract to FHKC were given the opportunity to review a draft issues outline and the list of our initial recommendations before any portion of the report was written. Much of the feedback MAXIMUS received has been incorporated into the final draft of the report.

It is important to clarify one other aspect of this project's scope and methodology. In developing our recommendations, we were not asked to consider their impact on program budgets. Therefore, MAXIMUS did not subject any of our recommendations to a rigorous

cost-benefit analysis nor did we decide which to include on the basis of existing or anticipated funding authority.

While we believe each recommendation in this report will improve the satisfaction level of KidCare applicants or enrollees, we also recognize that some of them will have a financial impact, either through short-term implementation costs or long-term operational effects. One of the key assumptions underlying this report is that the leadership of the various KidCare agencies will agree on which recommendations to collaboratively implement based partly on the fiscal realities facing the program.

In studying the program and developing our recommendations, MAXIMUS focused on three broad operational areas:

- *Key business processes.* MAXIMUS identified and documented the places where the KidCare business processes are most at risk of bottlenecks or inefficiencies. We paid particular attention to referrals to DCF of children who are potentially eligible for Medicaid and the timing of data matches to identify children who are currently enrolled in Medicaid or are the dependents of state employees.
- *Program transitions.* A disproportionate amount of interview time was spent looking at the problems and possible solutions associated with moving children from Title XIX to Title XXI and vice versa. These transitions are prompted by a change in income, age, or medical status and they usually coincide with a periodic eligibility re-determination.
- *Electronic data.* Because many of the KidCare business processes are linked to electronic data interfaces, we looked at the timing, security, and efficiency of these operations.

MAXIMUS acknowledges that not every recommendation in this report will enjoy the support of each KidCare partner. However, it is important to emphasize that we did seriously consider the feedback and perspective of each partner in drafting the final version of the report. When we made a recommendation that we knew would not enjoy unanimous support among the KidCare agencies, we did so out of a conviction that the proposed change would be operationally feasible and would result in a more positive consumer experience.

III. Basic Components of the Eligibility Determination Process

A. Key Participants

This section outlines the comparative responsibilities and operational roles that each of the primary entities plays in the eligibility determination process.

The Agency for Health Care Administration (AHCA) is Florida's designated single state agency for the Medicaid and Title XXI programs. In this capacity, AHCA is the state's principal contact with the federal government and oversees the day-to-day operations of the full Medicaid program, including KidCare Medicaid. Because MediKids operationally mirrors Medicaid, AHCA is also responsible for the day-to-day functions of MediKids.

As part of its Medicaid oversight functions, AHCA contracts with ACS to develop and maintain the Florida Medicaid Management Information System (FMMIS), a federally-required comprehensive computer system that contains all the relevant enrollment and provider information for each Florida resident who is currently receiving Medicaid benefits or is set to receive benefits as of the following month.

AHCA's primary roles in the KidCare eligibility determination process are facilitating an applicant family's choice of MediKids providers and as contract manager over ACS for the transmittal of the monthly Medicaid match results. In addition, in its capacity as the single state agency, AHCA also contracts with FHKC for Title XXI application processing and eligibility determination services.

The Department of Children and Families (DCF) is Florida's designated Title IV-A agency and conducts eligibility determination and enrollment functions for a variety of public assistance programs, including Medicaid. DCF develops and maintains FLORIDA, the state's comprehensive eligibility determination system for all public assistance programs except the Title XXI non-Medicaid programs. DCF also develops and maintains KISS, an intermediary system between the Title XXI eligibility determination system and FLORIDA. A Public Assistance Specialist (PAS) enters data from an application into FLORIDA and the determination is made and stored within FLORIDA.

DCF processes Medicaid applications from two sources: the KidCare application and the "Request for Assistance" (RFA). The RFA is a comprehensive gateway to cash assistance, food stamps, and all forms of Medicaid. The KidCare application is primarily a mail-in process while the RFA takes place through face-to-face interviews at local DCF offices.

The Florida Healthy Kids Corporation (FHKC) is a non-profit, statutorily-created private corporation that, through its contract with AHCA, is responsible for the following key steps in the KidCare eligibility determination process:

- Accept and process KidCare applications
- Screen KidCare applicants for possible Medicaid eligibility and make referrals to DCF for final Medicaid determination
- Generate correspondence
- Make final eligibility determinations for the non-Medicaid Title XXI programs
- Refer children with special health care needs to DOH for further CMSN screening
- Refer children ages 1 through 4 with family incomes between 133% and 200% FPL to AHCA for MediKids health plan or provider selection
- Collect and account for monthly premiums from Title XXI families
- Review the status of Title XXI beneficiaries in compliance with the six-month period of continuous eligibility

Over time, FHKC has contracted out the bulk of these responsibilities to DHACS, its third party administrator. In doing so, FHKC enforces quantitative performance standards

and provides quality assurance oversight. Likewise, the AHCA contract with FHKC gives the State the necessary framework to ensure reliable, accurate, and accountable eligibility determination services.

The Florida Department of Health (DOH) runs CMSN, the provider network that is available to children who are confirmed as having special, long-term health care needs. CMSN clinicians screen applicants who affirmatively answer a health status question to determine medical eligibility for CMSN (either through Title XXI or Title XIX).

The Department of Banking and Finance is responsible for performing the monthly match of Title XXI applicants and enrollees against the state database containing information about all current state employees and transmitting the results to DHACS. This match is necessary because federal law precludes Title XXI benefits to the dependents of workers who receive insurance benefits from a state agency.

B. Application Data

The foundation of the KidCare eligibility determination processes is a family's submission of a signed and properly completed KidCare application. Families or other interested parties can obtain the application and a related informational brochure by calling the KidCare hotline (which is run by a private company under contract to DOH), downloading the material from www.floridakidcare.org or www.healthykids.org, visiting a local DCF office, or contacting one of many community-based organizations involved in KidCare outreach throughout Florida. The application and brochure are available in English, Spanish, and Creole. Most applications are mailed to a post office box maintained by FHKC.

The application fits on a legal size piece of paper and is printed on both sides. Considerable effort has been made to adhere to a single-page application format and MAXIMUS concurs that this is a goal that should be maintained, regardless of any changes that are considered. The application collects the following types of information:

- *Parent/Guardian Information.* This is the first part of the application, and it collects the following data for each parent or guardian living in the applicant household: name, date of birth, sex, contact information, employer, and social security (SSN).
- *Applicant Child Information.* The following information is collected only for children in the household for whom health insurance is being sought: name, sex, date of birth, citizenship, relationship to parent/guardian, health insurance status, and existence of a long-term medical or developmental condition.
- *Household Data.* This section collects information designed to establish the household's size and conformity with criteria such as residence or loss of insurance. It also clarifies whether a child is being added to an existing account and whether there are any unpaid medical bills from the previous three months, which can be paid if a child eventually qualifies for Medicaid.
- *Income/Expense Data.* The application asks for the names of income-producing members of the household and gives several choices to list the source and amount

of income (such as "work" or "child support" or "SSI"). Because Medicaid deducts certain expenses from household income, there is also a section asking for information about payments made for care for a child and/or disabled adult.

- *Signature.* Each application must be signed by a parent or guardian listed on the first side of the application. Several legal statements precede the signature line.
- *Miscellaneous.* The last questions on the application ask for the applicant's language preference among English, Spanish, and Creole and solicit information about how the applicant learned about KidCare.

With the exception of immigration documentation for non-citizen children, all of the application information is self-attested, with no verification requirements. Applicants who answer "no" to the citizenship question or leave it blank are asked to provide immigration documentation in a follow-up letter, but this is not requested on the application or in the informational brochure.

Several program integrity safeguards are in place. As stipulated by federal regulations, DCF matches income information provided on the KidCare application for families who are referred to DCF with various public databases, including the IRS, Social Security, unemployment compensation, and stage wages. Public Assistance Specialists investigate income discrepancies as they are found. FHKC audits randomly selected samples of applications and requests income documentation as needed. When families with anomalous income situations are identified, FHKC requires verification as well.

The availability of toll-free assistance is noted several times on the application. There are brief instructions at various places on the application and the informational brochure also contains several instructions. The application does not distinguish between information that must be provided as a pre-requisite for an eligibility determination (such as a child's date of birth or health insurance status) and information that is provided voluntarily (such as a parent's SSN). Neither the application nor the brochure explains why certain types of information are requested (such as the health status question or the section pertaining to day care expenses).

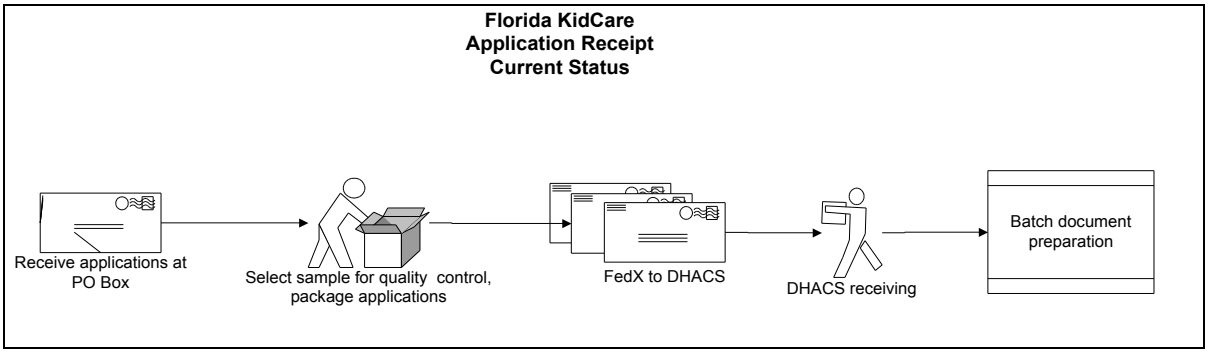
Consumer research conducted by the Institute for Child Health Policy convincingly shows that families in Florida appreciate the simplicity and design of the KidCare application. When the next Application Workgroup is convened, possibly later this year, we believe that some relatively minor modifications are worthy of consideration to make a good product even better.

C. Application Processing

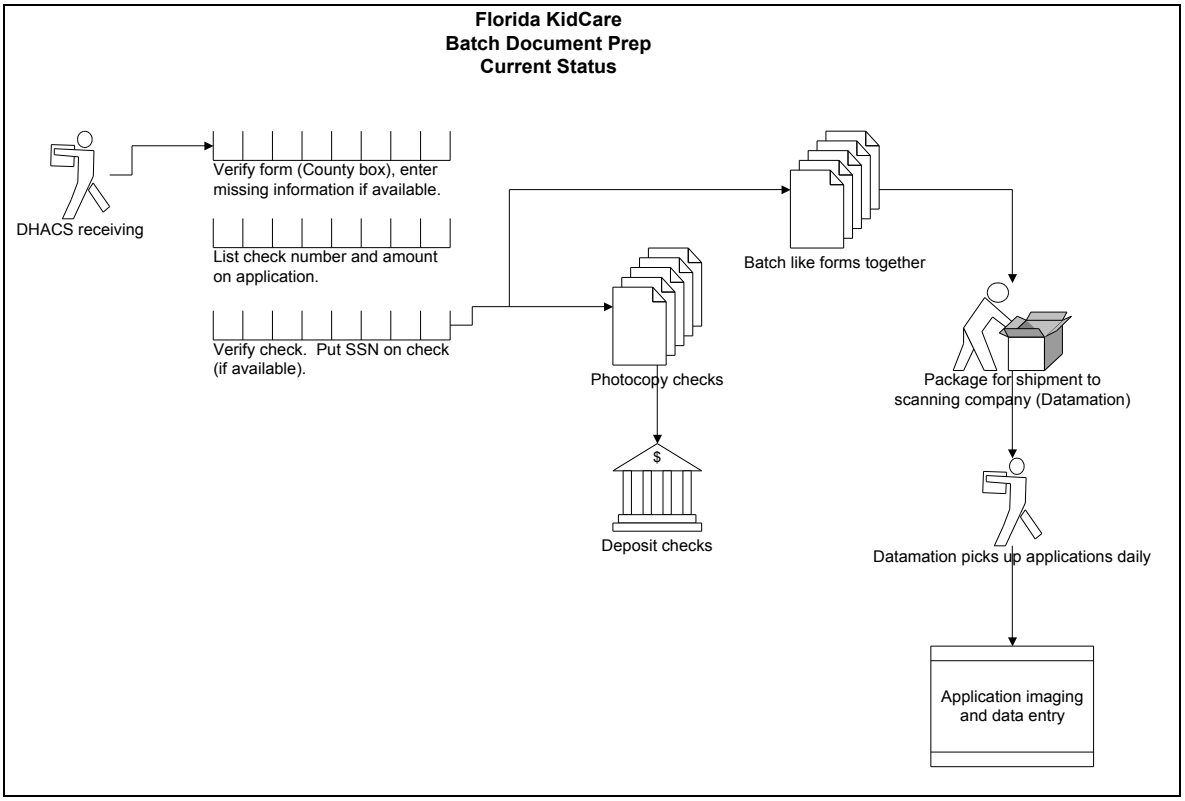
This section of the report outlines in text and illustrations the steps that move a KidCare application from a written document to an electronic record that is then capable of being processed automatically by applying the Medicaid and Title XXI eligibility algorithms.

- Applications are mailed to PO Box 980 in Tallahassee, Florida (32302 zip code).

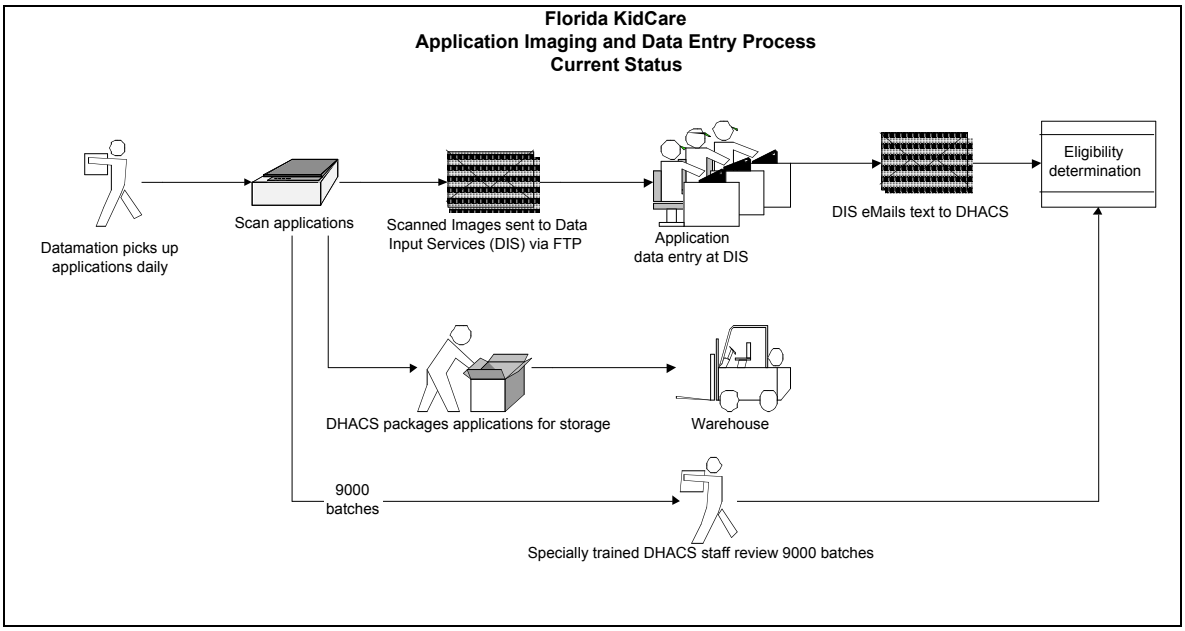
- FHKC staff empty the post office box daily and randomly select and copy a group of applications to monitor for quality assurance purposes. These applications are tracked to ensure timeliness of handling and data entry accuracy.
- The applications are boxed and shipped via Federal Express to DHACS.
- Upon receipt of the Federal Express shipment, DHACS employees open the individual envelopes and sort the applications into specific categories or "batches."



- If an application is missing "county" data, DHACS staff will manually add that information to the application by cross-referencing zip code or city data (the county of residence is a key factor in assigning an eligible child to the appropriate health plan).
- If a check or money order is included (as recommended in the application), the applicant's SSN, if available, is written on the check, which is photocopied and deposited.
- Applications that are identified during intake as posing unique processing challenges are assigned to a special "9000" batch
- Datamation, a DHACS subcontractor, picks up the batches and converts the applications into electronic images using high-speed scanning technology.



- The electronic images are sent via FTP to Data Input Services (DIS), another DHACS subcontractor. The information from an application is typed into an electronic form directly off of the electronic image. Paper documents are not used during the data input process.
- The paper documents are returned to DHACS, where they are boxed and stored by batch in an onsite warehouse.
- The 9000 batch applications are routed to specially trained DHACS staff.
- DIS e-mails an electronic file containing the application data back to DHACS for loading into CHAS, the automated eligibility determination system.



D. Automated Systems and Data Interfaces

The application processing volumes associated with Florida KidCare are among the highest in the country compared to other SCHIP programs. During the most recent state fiscal year, roughly 160,000 applications were received at PO Box 980 representing almost 300,000 applicant children. Given these volumes, it is not surprising that the program relies heavily on automated systems to make eligibility determinations and maintain enrollee accounts. Similarly, the electronic exchange of information among the KidCare partners is a vital part of the program infrastructure. Without these electronic interfaces, the timeliness and reliability of the overall eligibility determination process would inevitably suffer.

The following are the key KidCare automated systems:

- *CHAS.* This is a "client/server" application developed and maintained by DHACS through a systems subcontractor. CHAS data is stored in a Microsoft SQL server database with a Windows-style interface developed in Microsoft Visual FoxPro. CHAS performs all of the critical administrative functions that occur after application data is entered and downloaded into the system, including Title XXI eligibility determinations and re-determinations, Medicaid screening and referral, generation of form letters, customer support, and cost sharing.

- *FLORIDA.* This is a mainframe legacy system developed and operated by state technical staff at DCF. Data is stored in an IBM IMS database with an IBM CICS interface. FLORIDA is the state's eligibility system for the primary health and human service programs: TANF (cash assistance), Food Stamps, and Medicaid (including Medicaid for adults, disabled persons, and children). It also processes information for KidCare applicants who are identified as potentially eligible for Medicaid. When a person is determined eligible for Medicaid, FLORIDA passes that information to FMMIS (the primary Medicaid enrollment and payor system).

Medicaid eligibility information is continuously maintained within FLORIDA, even after a beneficiary is enrolled within FMMIS, to facilitate two key operations: periodic re-determination of Medicaid eligibility and periodic income matches against the IRS, Social Security, unemployment compensation, and stage wage databases.

- *KISS.* When the joint application was created in response to the KidCare legislation, there was a need for a "stop-gap" solution that could be developed and implemented to handle the referral of children to DCF who were identified as potentially eligible for Medicaid. KISS is this "stop-gap" system, and it acts as an intermediary system between CHAS and FLORIDA. DCF technical and operational staff do not view KISS as a long-term approach, however, because the data that is imported from CHAS into KISS must be manually re-entered into FLORIDA by DCF staff at one of four central processing units (CPUs) located throughout the state. Similarly, when DCF finishes processing a KidCare referral within FLORIDA, the disposition of the referral must be manually entered into KISS for export into CHAS.

- *FMMIS.* Under federal Medicaid law, each state is required to have a Medicaid Management Information System and FMMIS meets this requirement in Florida. FMMIS is important within the KidCare infrastructure for two reasons: it is used to identify KidCare applicants and Title XXI enrollees who are currently enrolled in Medicaid (and are therefore ineligible for Title XXI benefits) and it administers benefits to MediKids enrollees.

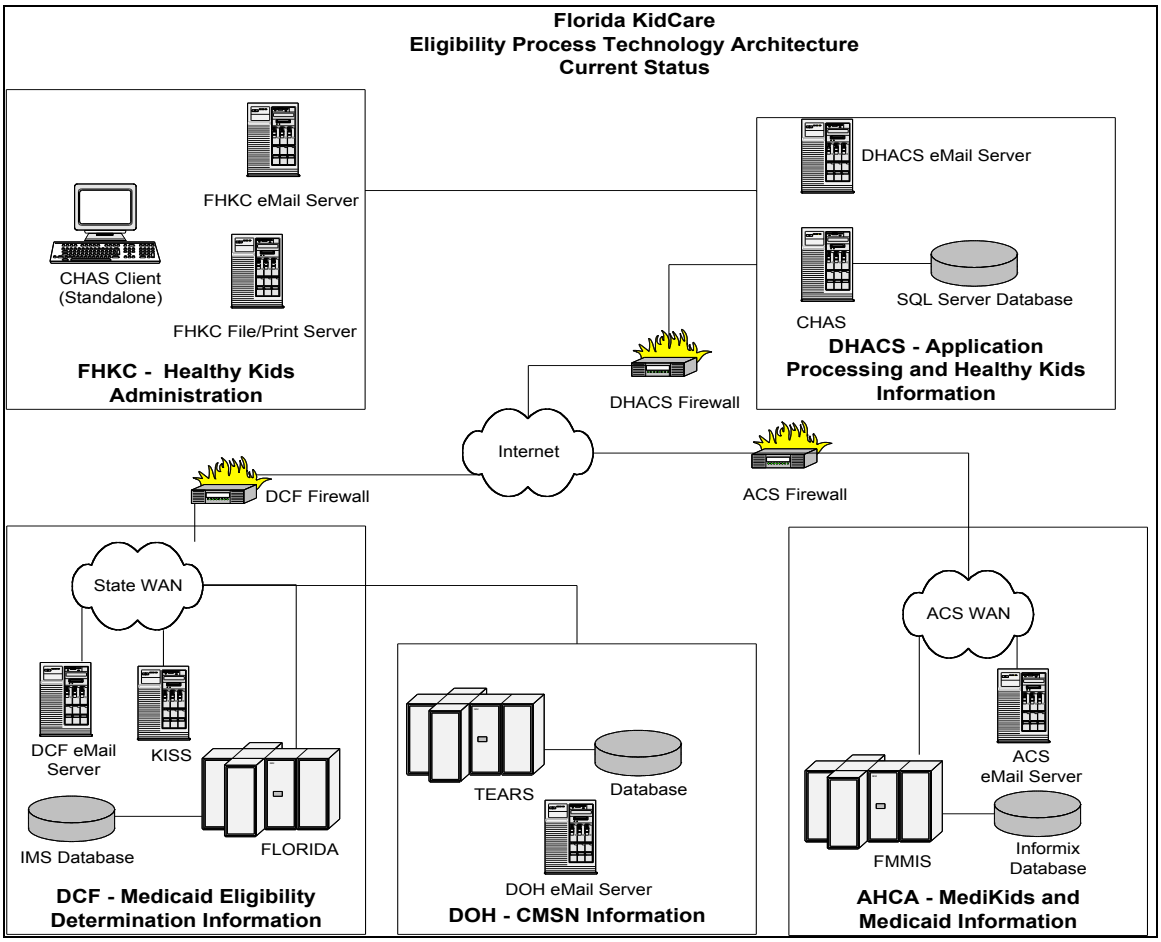
- *TEARS.* DOH developed and maintains this Intranet system to electronically distribute to regional offices information about children who may be eligible for CMSN because of a long-term developmental or medical condition. TEARS is also used by regional staff to report the results of clinical screenings that confirm or deny CMSN eligibility for specific children.

Two DHACS subcontractors also employ electronic systems to import and/or export data. Datamation (the scanning subcontractor) sends application images to DIS (the data input subcontractor) and also delivers application images via CD to DHACS. After application data is entered into a temporary database, DIS converts it on a daily basis to an export file that is sent to DHACS as an e-mail attachment.

The network infrastructure that ties the various KidCare systems together is depicted graphically in the following illustration. (The Department of Banking and Finance system is not included because it is not a KidCare system *per se* but rather a system that facilitates one aspect of the eligibility determination process.)

With only two exceptions, all electronic data that flows between the KidCare partners goes over the Internet in some way. The exceptions are application images, which are delivered to DCF on a weekly basis on a CD, and data backups to FHKC, which are conveyed via Frame-relay. When data is exported from one system and imported into another, it is

typically done using ANSI text files containing fixed length records. The data exchange protocols are "manual" in the sense that a person at one location must do specific things to generate and send the electronic file and another person at the receiving end must carry out certain steps to retrieve the file and download it to the destination system. An automated approach, by contrast, would occur at regularly scheduled intervals without human intervention at one or both ends of the transfer process.



Given its primary role as the KidCare application screening system, it is not surprising that CHAS is involved in most electronic exchanges of information among the KidCare partners.

Data matches or data look-ups are built on a variety of criteria, with parent or child SSN playing a key role (when that information is provided on an application). However, because an application may be processed without any SSNs, other values are also used to detect matches, including name, date of birth and address.

On a daily basis, DHACS generates and sends a file containing Medicaid referrals to DCF. A designated person at DCF retrieves this file, which is sent as an e-mail attachment, and loads it into KISS. After the daily referral file is loaded in KISS, the individual records

are parsed out to one of four central processing units (CPUs) on an equally proportional basis. The data within KISS is then printed and, as DCF staff manually type the relevant information into FLORIDA, new eligibility cases are created within FLORIDA.

After a KidCare referral is worked to completion, a code associated with disposition of that referral is entered into KISS. On a daily basis, all new disposition records are loaded into a file and sent electronically to DHACS via e-mail attachment. Most children who are denied Medicaid and returned to DHACS resume the Title XXI eligibility determination process.

In a manner similar to the interface with DCF, files are sent between CHAS and TEARS via e-mail attachments. On a daily basis, CHAS generates a file containing the records of children who were identified on the application by their parents or guardians as having a long-term developmental or medical condition. Similarly, TEARS produces a daily file containing the clinical disposition of the CMSN referrals.

The data link between CHAS and FMMIS occurs through a password-protected and encrypted protocol via a website maintained by ACS (the AHCA contractor). On a weekly basis, DHACS sends a file to ACS containing children who require a MediKids health plan or provider choice to complete the eligibility determination process. On the first two or three Fridays of the month (depending on the number of Saturdays in a month), DHACS retrieves a file from the ACS website containing MediKids health plan or provider choices.

During the first week of the month, DHACS sends ACS, via the secure website, a file containing current Title XXI enrollees and KidCare applicants. ACS matches that data against the FMMIS system and posts the results of the match on the website for retrieval by DHACS. Positive matches are disenrolled or are denied eligibility unless they are full-pay FHKC account holders and are not subject to the state employee restriction.

The timing of the monthly match is a critically important factor in determining how long it takes for a child to reach a Title XXI eligibility determination and begin coverage. Since passing the match is a pre-requisite to Title XXI eligibility, any applications that are received after the monthly match must wait until the next match to complete the determination process. If the match occurs on the 2nd day of the month, applications that are data-entered or loaded into CHAS on the 3rd effectively must be held up for an entire month, even if they are complete in every other respect.

On a monthly basis, DHACS also sends ACS a regular and a supplemental file containing all children who have been determined eligible for MediKids coverage. The timing of this transfer is related to the comprehensive automated processes that produce the monthly file of individuals eligible for Medicaid as of the first day of the following month. This process is called “Month End Processing,” occurs on the next-to-the-last Saturday of the month.

While a MediKids “supplemental” file is also run at the end of the month, this file does not include newly eligible children. The only way a child can start MediKids coverage is through the regular monthly enrollment file that is created as part of the “Month End

Processing" procedures, which usually occurs prior to the generation of the monthly Healthy Kids coverage file at DHACS. These differing schedules mean that children within the same family can have different coverage start-dates.

For example, if a family has a 3-year-old daughter eligible for MediKids and a 12-year-old boy who has qualified for Healthy Kids, the boy's health coverage would start a month earlier than his sister if the family's application is ready for final eligibility determination at a point in the month following "Month End Processing" but before the Healthy Kids cut-off.

The monthly state employee match occurs via an encrypted exchange of data using the File Transfer Protocol (FTP). The timing and impact of this match is similar to the Medicaid match. Within the first three business days of the month, DHACS sends the Department of Banking and Finance a file containing parent information for current Title XXI enrollees and KidCare applicants. This file is matched against the state employee database. Positive matches are disenrolled or denied eligibility.

Like the Medicaid match, the timing of this operation directly affects how long it takes for a child to reach a Title XXI eligibility determination and begin coverage. Since passing the match is a pre-requisite to Title XXI eligibility, any applications that are received after the monthly match must wait until the next match to complete the determination process. MAXIMUS heard from multiple individuals that the monthly Medicaid and state employee matches were the single most important factor affecting the timeliness of an eligibility determination.

E. Identification and Collection of Missing Information

Because Medicaid and the Title XXI programs are based on eligibility criteria that are directly related to items on the application, it is not possible to either screen for Medicaid or make a Title XXI determination if certain items on the application are left blank or are incomplete. When CHAS identifies an application that is missing one or more items that are a pre-requisite to an eligibility determination, correspondence is automatically generated seeking the missing item(s).

The progress of an application is stopped ("pended") if any of the following occur (and the application remains pended until the required information is received via phone or mail):

- Income information is incomplete or missing (phone or mail)
- Child or disabled adult care expense data is incomplete (phone or mail)
- A parent or guardian's signature is missing (mail only)
- Applicant child's date of birth is missing (phone or mail)
- Applicant child's relationship to the parent or guardian listed on the application cannot be determined (phone or mail)
- Applicant child's current insurance status is missing (phone or mail)
- Applicant child's citizenship status is missing (phone or mail)

There are two other types of critical missing information that are treated somewhat differently within CHAS. If the question pertaining to number of adults and children in the household is left blank, or a non-citizen child is listed, the application proceeds to the Medicaid screen. If a child is found to be potentially eligible for Medicaid, the child is referred to DCF and a PAS solicits the required immigration documentation. DCF will not seek an answer to the household size question because it is only applicable to Title XXI eligibility. If DCF determines the child is not eligible for Medicaid and sends the application back to DHACS, it is pended for Title XXI purposes until the number of adults and children in the household is clarified (phone or mail).

While the household size data that is collected on the application meets the needs of Title XXI, it is insufficient for Medicaid because that program determines which household members to count on the basis of relationships and age. A PAS will need to solicit missing information about non-applicant siblings when the number of children in a family is greater than the number of children actually listed on the application.

There is one additional data element that is a requirement for Medicaid but is optional for the non-Medicaid Title XXI programs: the SSN of an applicant child. Around 15% of applications come in without applicant children SSNs. Those that are referred to DCF are pended until a PAS can contact the family and obtain this information.

It is very common for KidCare applications to be pended for missing information. Between July and December 2001, around one-third of all applications were held up for that reason. Because neither the application nor the informational brochure ask for immigration documentation for children who are marked as non-citizens, it is not surprising that a disproportionate number of missing information letters are sent out for this reason. Between July and December 2001, 27,556 applications required immigration documentation, or 16% of the total. This does not include those applications that passed the Medicaid screen and prompted a subsequent immigration documentation request at DCF.

The way in which CHAS processes applications that answer "no" to the citizenship question or leave it blank is unusual in several respects. First, a separate immigration documentation "missing information letter" is sent for each non-citizen child within a family. For instance, if a family indicates three non-citizen applicant children (by checking the "no" box or leaving it blank), the family will receive three separate missing information letters on or about the same day. Second, if a family tries to expedite the processing of their application by sending in the necessary documentation with the original application, the system will still generate the missing information letter(s). In this case, the application and immigration documentation will be routed to the special "9000" batch at intake for review by specially trained DHACS staff. But this review will not prevent the automatic generation of a letter for each non-citizen child.

There are three basic missing information letter templates: one for immigration documentation (written at the child level); a separate letter to collect a missing signature (this letter has a signature line that is appended to the application); and a third letter for all other

categories (written at the family level). This means that it is at least theoretically possible for a family to receive three or more missing information letters on the same day: one for a missing signature, separate immigration documentation requests for each non-citizen child, and a different letter soliciting the remaining missing information (such as the children's dates of birth).

While this is not a common event, neither is it rare. During the July-December period previously mentioned, 16,410 families received multiple missing information letters, over half of which were sent to families with more than one non-citizen child.

When a child is referred to DCF and the application is lacking information that is a pre-requisite to a Medicaid determination, a PAS will initially try to contact the family by phone. If this effort is unsuccessful, a letter is sent requesting a response within ten days.

F. The Medicaid Screen-and-Refer Process

When Congress adopted Title XXI as part of the 1997 Balanced Budget Act, it gave states considerable flexibility and latitude in creating and implementing state-designed SCHIP programs. One area where that flexibility did not extend, however, is the screening of applicant children for Medicaid.

For reasons that are partly budgetary (Title XXI has a more generous federal match than Title XIX) and partly policy-based (Medicaid is an entitlement unlike most state-designed programs), the federal statute is clear that a child must first be found to be ineligible for Medicaid before being determined eligible for a state-designed SCHIP program. This requirement is particularly relevant in states that have different ways of calculating a family's FPL under Title XXI and Medicaid (as Florida does).

The federal statute is not so rigid or literal as to mean that DCF must become involved in every KidCare application before DHACS can make an affirmative Title XXI finding. It does mean, however, that the CHAS system must first subject an application to the Medicaid eligibility rules before the Title XXI algorithm can be applied.

According to DCF records, a quarter-million children were referred by DHACS to DCF between November 2000 and October 2001. Roughly one in seven of these children were already enrolled in Medicaid, making those referrals unnecessary if this information had been known by DHACS. Of the remaining children, approximately two-thirds were approved for Medicaid coverage and one-third were denied.

When DCF reports a Medicaid denial as part of its daily disposition file, a reason is provided for the denial. Denials that occur for reasons other than voluntary withdrawal of the application or failure to cooperate with DCF are put back on the Title XXI eligibility track. A majority of these children eventually qualify for Healthy Kids, MediKids, or Title XXI CMSN.

The proportion of "false positive" referrals---those that did not result in Medicaid eligibility---tracked at DHACS is roughly half the figure cited by DCF, while the Institute for Child Health Policy (ICHP) reports a number roughly in-between the DCF and DHACS estimates. Possible reasons for the discrepancies among the three entities are differences in reporting criteria and methods, the inherent unreliability of manual disposition data-entry into KISS, and the lack of an electronic interface between the two principal eligibility systems (CHAS and FLORIDA).

Whether the actual number is closer to the DHACS or DCF figures, it is nevertheless true that a considerable number of children are unnecessarily referred to DCF. These false positive referrals are undesirable in three respects: they take longer to process, and for some families that means a delay in coverage of an additional month; they result in additional work at DCF; and they are confusing to some families.

The relatively high proportion of false positive referrals to DCF can be explained by an operational philosophy that consciously errs on the side of too many referrals rather than the reverse. This philosophy reflects a belief that the federal statute is unyielding in its insistence that Medicaid-eligible children not be enrolled in a Title XXI program.

A second category of referrals to DCF is the current method of handling Title XXI families who report a downward change in income or an increase in family size. Even though each non-Medicaid Title XXI determination comes with six months of continuous eligibility, when a Title XXI family reports a change in income that falls within the Medicaid screen parameters, the enrolled children are referred to DCF. The children are disenrolled from Title XXI if they subsequently appear in the monthly Medicaid match file.

The following is a high-level description of the business rules that CHAS uses to determine which applicant children should be referred to DCF for further Medicaid eligibility evaluation:

- General eligibility levels
  - Children 0 up to first birthday, at or below 200% of the Federal Poverty Level (FPL)
  - Children ages 1 through the sixth birthday, at or below 133% FPL
  - Children ages 6 through the nineteenth birthday, at or below 100% FPL

- Treatment of an "Intact Family"
  - Defined as a household where both the child's biological or adoptive mother and father are living in the home
  - All non-child income is counted
  - Family size consists of the mother, father, and children

- Treatment of a "Single Parent Family"
  - Defined as a household where only one parent lives in the home
  - All non-child income is counted
  - Family size consists of the parent and children

- Treatment of a "Non-Parent Household"
  - Defined as any child or children not living with a parent in the household (the child lives with a relative or a non-related adult)
  - No income is counted
  - Family size consists of the child or children

- Treatment of a "Family with Step-Parents"
  - Defined as a household including at least one natural or adoptive parent and a step-parent
  - Only count natural/adoptive parent and natural/adoptive parent's income when determining a non-mutual child's eligibility
  - For a mutual child's eligibility, count both parents and all siblings and both parent's income

- Disregards and Other Factors
  - Each parent with earned income receives a $90 monthly deduction
  - The first $50 of child support income is disregarded
  - Child and disabled adult care is deducted subject to a $200 monthly limit for each child under age two and $175 for each disabled adult or child over age two
  - SSI income is not counted and the person who receives SSI income is not counted in the family size
  - Because SSI income may be confused with Social Security income, income related to Social Security is also disregarded
  - The documented status of non-citizen children is not considered in screening for Medicaid

G. Screening Special Needs Children for CMSN Eligibility

In Florida, children with long-term developmental or medical conditions who also qualify for a Title XXI or Title XIX program should receive their benefits through the Children's Medical Services Network (CMSN). The Department of Health (DOH) runs CMSN by contracting with providers throughout the state who are uniquely qualified to handle children with chronic illnesses, disabilities, or other qualifying medical or behavioral health conditions.

Clinical staff located at regional DOH offices determine eligibility for CMSN on the basis of medical condition (as opposed to Title XXI or Title XIX criteria). Once a child qualifies for CMSN on this basis, the eligibility remains in effect for 12 months for medical conditions and six months for behavioral conditions. This medically-related eligibility is separate and apart from the 6 or 12-month eligibility increments associated with the Title XXI programs and Medicaid.

Children are referred to CMSN by providers and health plans, and through a health status question included on the KidCare application. DOH clinicians apply a multi-tiered

screening tool to evaluate these children. Most of the questions in the tool rely on family attestation. Only in unusual cases does a DOH nurse review medical records or rely on a physician exam. According to CMSN executive staff, the use of DOH clinicians to confirm medical eligibility produces results that can be unpredictable and varied, given the clinical judgment that is inherent in the process.

When a family begins the process at a regional DOH office, as the result of a physician referral, and a child is confirmed eligible for CMSN services, the family receives a KidCare application with a "CMSN" stamp at the top and next to the qualifying child's name. When DHACS receives a KidCare application with these stamps, it is assigned to a special batch ("9000") for handling by specifically trained enrollment staff who register the child's eligibility for CMSN within CHAS, thereby circumventing the normal electronic CMSN referral process.

When DHACS receives an application with at least one "Yes" response to the health status question, data associated with the application is sent to DOH via the TEARS system and it is then referred to the appropriate regional office based on the family's county of residence. Eligibility for CMSN is confirmed or denied within 15 working days. During this time, the application continues through the normal Medicaid screening and Title XXI eligibility determination processes. Referral to CMSN for clinical review does not result in the application becoming stuck in the process. If a child is found eligible for Title XXI and the CMSN determination is not yet received, the child will be enrolled in MediKids or Healthy Kids. Then if the child is subsequently found to qualify for CMSN, enrollment will switch to CMSN. In that circumstance, the child's eligibility for Title XXI benefits remains unchanged, as does the six-month period of Title XXI continuous eligibility.

The vast majority of children referred by DHACS through the TEARS system are not approved for CMSN. According to the most recent KidCare Annual Evaluation, 16% of the children who were indicated on the KidCare application as having a long-term developmental or medical condition were certified for CMSN (11% for the Title XXI programs and 5% for Title XIX). Another way of putting this is that 84% of the children sent by DHACS to CMSN for clinical screening fail to qualify. Like the Medicaid false positives, this high denial rate implies a considerable amount of DOH labor that is ultimately proven to be unnecessary. Unlike the Medicaid false positives, however, this relatively low approval rate has no adverse impact on eligibility determination timeframes.

While the KidCare application provides a way for a family to initiate the CMSN screening process, the Title XXI re-determination process fails to provide this opportunity. This means that if a child's health status experiences a negative change after the initial Title XXI eligibility determination, there is no systematic way for that fact to be communicated to CMSN. Of course, it is possible that the child's health plan or primary care provider will make a referral. But within the context of the eligibility re-determination process, there is currently no link to the CMSN program.

Children who qualify for Title XXI benefits and CMSN coverage are tracked within the CHAS system and are captured within the normal daily and monthly electronic exchange

of information between DHACS and DOH. There is no similar electronic interface between CMSN and the Medicaid program, either within the FLORIDA or FMMIS systems. Although CMSN is the preferred provider network for Medicaid-eligible children who meet the clinical criteria, there is no current electronic process to ensure that the Medicaid program knows when a child who has been determined eligible for Medicaid should be assigned the CMSN option. Instead of an automated process, Medicaid-eligible children typically enroll in CMSN with the assistance of a regional DOH clinician or through the referral of a health plan or physician.

H. Determining Eligibility

From a consumer standpoint, probably the most important quality of the eligibility determination process is timeliness. Ideally, there should be no bottlenecks or structural impediments to a prompt determination and commencement of health coverage.

When considering the timeliness of an eligibility determination, it is worth remembering that non-Medicaid health coverage does not begin at the same time as a favorable determination. Depending on when a child is found eligible, coverage may begin the first day of the next month or the first day of the month after that. Because going through the monthly Medicaid and state employee matches is a pre-requisite to Title XXI eligibility, it is fairly common for almost a month to elapse between a favorable Title XXI determination and the onset of coverage.

Processing timeliness is not as critical for children who are found eligible for Medicaid because that program pays for medical costs that accrue during the three months prior to the date of DHACS referral to DCF. But it is very important for families who qualify for non-Medicaid Title XXI, because CMSN, Healthy Kids, and MediKids only cover medical costs that occur on or after the first day of coverage (which is always the first day of the month).

There are two key factors affecting timeliness: the program design and the time it takes a family to respond to a missing information letter or a premium payment bill. The only impact the program can have on family response time is ensuring that correspondence is written clearly and at an appropriate reading level and telephone follow-up occurs as warranted. Otherwise, delays that result from family non-responsiveness are outside the responsibility of the program. Instead, the program's obligation is minimizing the time an application is pended purely for processing reasons.

To find out how long it takes a typical application to reach the determination stage, MAXIMUS interviewed FHKC, DHACS and DCF management and compared those responses to the information contained in the most recent KidCare Annual Evaluation report. By and large, there were no notable discrepancies between the feedback we received from the operational entities and the report as published by the Institute for Child Health Policy (ICHP) with one exception: the time it takes to process an application that involves a "false positive" referral to DCF.

The average time it takes for a KidCare application to reach an eligibility determination depends on whether a Medicaid referral occurs. Title XXI determinations for children who are not referred to DCF typically occur within 21-30 days of an application's receipt, according to DHACS management and within an average of 27-30 days according to ICHP. A child who is referred to DCF and found eligible for Medicaid typically must wait around 14 days from the time the application is received at DCF until the determination occurs.

The Annual Evaluation report estimates that a DCF false positive referral only adds 3-5 days to the total processing time while DHACS believes a referral extends the timeframe by around 17 days.

At first glance, the DHACS estimate seems more credible and the shorter processing time for a DCF referral that results in a Medicaid determination seems implausible. After all, why should it take significantly less time to process an application that involves a referral to a completely different agency than an application that is processed completely in-house at FHKC's third party administrator? And why wouldn't the referral to DCF add more than 3-5 days, just considering the manual effort that is required to move an application from KISS to FLORIDA with PAS involvement occurring at one of the four central processing units?

The answers to these questions become clear as one considers the impact of the monthly Medicaid and state employee matches, which only occur in regard to Title XXI eligibility determinations. A child who is referred to DCF and determined eligible for Medicaid effectively avoids the match processes. Any child who is subject to the match processes---and that includes both "false positive" DCF referrals and children who are never referred to DCF---must wait for them to occur before the application reaches its final stages. Depending on when the application is originally received and missing information arrives, the monthly matches can have a dramatic impact on timeliness.

Specifically, any application that is received just after the monthly matches occur is pended for virtually an entire month, even if it is complete in every other respect. Because the monthly match effectively blocks the progress of any application, including "false positive" referrals to DCF, it is easy to see why a Title XXI determination necessarily takes longer than a Medicaid finding and it also explains why a "false positive" referral does not take significantly longer than an application that is never referred to DCF.

The other structural factor that significantly blocks the timely processing of a Title XXI application is the schedule for updating MediKids provider choices and generating the monthly MediKids enrollment file. Unlike a child who qualifies for Healthy Kids or CMSN, a MediKids child cannot complete the eligibility determination process until he or she has been assigned to a health plan. A family is initially given 14 dayss to make a choice and if it fails to respond by the deadline, an AHCA staff-member assigns the child to an HMO or MediPass.

Because MediKids provider choice files are sent electronically to DHACS only on the first, second (and sometimes third) Fridays of the month, it is possible for a MediKids child to

have to wait an extra month for coverage to begin. This is because if a provider choice is made or assigned during the final two weeks of the month, this information will not be received at DHACS until the first Friday of the following month. It is also because newly eligible children may not be added to the supplemental MediKids enrollment file that is generated near the end of the month.

On a daily basis, CHAS attempts to recalculate eligibility for all applications that are pending a determination. An application can be in a pended state for several reasons: critical information is missing; immigration documentation or a signature are needed; a premium payment is missing; the monthly Medicaid and state employee match has not yet occurred; or the disposition of a Medicaid referral has not yet been received. Each time an application meets one or more of these milestones, CHAS notes that within the record. Once all required conditions have been met for a particular application, CHAS calculates final non-Medicaid Title XXI eligibility for each applicant child.

While the Title XXI eligibility determination process occurs completely at DHACS with most steps fully automated, the KidCare Medicaid process at DCF unfolds at several locations and, depending on whether an applicant family previously applied to DCF, may involve several Public Assistance Specialists and one or more manual processes. The following are the primary steps DCF staff use in assessing the Medicaid eligibility of a child who is referred from DHACS based on a KidCare application:

- Each referral is printed out from KISS in hard copy and this hard copy is used for manual look-up and data entry purposes.
- Administrative Unit Interviewing Clerks enter referrals in FLORIDA and do look-ups in FMMIS to identify children who are already enrolled in Medicaid or have open eligibility cases in FLORIDA.
- Each child who is not enrolled in Medicaid and does not have an open case in FLORIDA is handled within one of the four KidCare central processing units (CPUs), based on his or her county of residence.
- Each new applicant child is handled by a PAS within the appropriate CPU; the PAS solicits any missing information and makes the final Medicaid eligibility determination.
- If a referred child has an active case within FLORIDA, the referral is assigned the same case number and the application is sent to a PAS who is already assigned to the case and who does not work out of a CPU (this happens because the FLORIDA system, for security reasons, only allows the PAS assigned to the case the right to modify the case and that open case may also include non-Medicaid benefits such as food stamps or cash assistance).
- Periodic data matches are made with various state and federal databases to corroborate income information.
- When a discrepancy between the income databases and the application data is identified, the PAS assigned to the case investigates and takes action as needed.

I. Re-Determining Eligibility

The Florida KidCare Act provides for six months of continuous eligibility for any child who qualifies for a non-Medicaid Title XXI program. Children under the age of five who qualify for Medicaid are entitled to 12 months of continuous eligibility while 5-18 year-olds on Medicaid receive a six-month period. Medicaid re-determinations are handled by DCF while DHACS performs non-Medicaid Title XXI eligibility renewal.

The Medicaid re-determination process usually begins in the month prior to the month in which eligibility ends. A family is sent written material and must respond by a deadline to avoid a break in coverage. Failure to send the re-determination information to the appropriate DCF office results in a denial of Medicaid.

The non-Medicaid Title XXI re-determination process is different because failure to reply does not result in automatic loss of eligibility. Before a child's six-month eligibility period ends, DHACS contacts the family and asks for updated information if the household size and/or income have changed. This process is considered "passive" because failure to respond to the notice is interpreted as confirmation that the prior information remains in effect. In the most recent KidCare Annual Evaluation report, this process---which is characterized as "family-centered"---is credited with helping foster a high retention rate compared to other states.

The 12 and 6-month continuous eligibility periods overrule a change in eligibility prompted by a child's birthday. This means, for instance, that when a Medicaid child from a family with an income greater than 133% FPL turns one, the transition to the next program (MediKids) is not immediate. Rather, it coincides with the next re-determination cycle. Therefore, it is theoretically possible for a child to remain in Medicaid until almost the second birthday. This fact complicates the transition of children from Medicaid to one of the non-Medicaid Title XXI programs since it is not possible to automatically time the switch to coincide with a child's birthday.

The most critical issue associated with the re-determination process involves the transition of a child from one program to another due to a change in age, family size, or income.

When children move from one non-Medicaid Title XXI program to another, this transition can be easily accommodated because eligibility and enrollment in each program is controlled by the same automated system (CHAS). The effectiveness of this single-system approach is confirmed in the most recent KidCare Annual Evaluation report, which showed that 96% of children moving from MediKids to Healthy Kids made the move seamlessly, with no gap in coverage. Transition of children from a Title XXI program to Medicaid is trickier but not particularly risky, since a gap in coverage is mitigated by Medicaid's retroactive coverage policy.

The transition of children from Medicaid to one of the non-Medicaid Title XXI programs, however, is difficult to manage and one or two month gaps in coverage are very common. Because Title XXI coverage is prospective, rather than retroactive, a gap in coverage is a serious problem for any family, particularly those with children who have

special health care needs or are recovering from an illness or injury. In our interviews with various KidCare partners and other stakeholders, the difficulty of maintaining coverage through this transition was repeatedly cited as the most important consumer problem facing the KidCare program.

If a family tries to avoid the gap by submitting a KidCare application several months prior to the expected end of Medicaid coverage, eligibility is likely to be denied based on the monthly Medicaid match. If a family waits until coverage ends or is about to end, the timing of the state employee and Medicaid monthly matches will assure at least a month's gap in coverage, and if the KidCare application is incomplete or no premium payment has been received, the gap will likely be longer.

The difficulty in arranging a seamless transition from Medicaid to a non-Medicaid Title XXI program is based in several operational realities:

- Separate eligibility systems are used and these systems have no means of communicating with one another, either through regular data exchanges or through a "real-time" data link
- There are two methods of becoming eligible for Medicaid, one through FLORIDA and the other through the Social Security Administration via FMMIS
- Because Title XXI uses a different eligibility algorithm than Medicaid, DCF Public Assistance Specialists are unable to screen children for Title XXI at the time they are denied Medicaid
- The monthly match against FMMIS does not take into account a child's Medicaid end-date

While it is possible to "shepherd" a child through the transition by manually overriding certain features in CHAS, such a labor-intensive approach is not feasible considering how many children are denied Medicaid on a monthly basis. And any business process that depends on manual overrides or "work-arounds" will be susceptible to error.

The current approach to addressing the gap-in-coverage issue involves the use of the form commonly referred to as "2092." When a child is denied Medicaid as a consequence of the re-determination process, a PAS completes a 2092 form, which includes the end-date of coverage and the reason for denial. This form, which a PAS completes by hand, is intended to serve two purposes: prevent an unnecessary referral by DHACS back to DCF and ensure that the child's current Medicaid enrollment does not block a Title XXI eligibility determination.

The deployment of the 2092 form varies, depending on the circumstances of the child's original application. If a child enrolls in Medicaid as the result of a KidCare application and is subsequently determined ineligible for Medicaid, then a 2092 is sent to the Florida Healthy Kids Corporation. If a child enrolls in Medicaid through initial contact with DCF, then a 2092 is given to the family along with a KidCare application and the family is asked to complete the application and return it with the 2092 form.

FHKC eligibility determination processes and staffing levels are built on an automated model. Therefore, when DCF forwards to FHKC individual 2092s without supporting documentation, FHKC does not process them because they are manual forms and any links to existing KidCare accounts at DHACS are not readily apparent without manual intervention. Conversely, when DHACS receives an application with a 2092 form enclosed, an enrollment specialist uses the 2092 information to override the DCF referral process. However, the existence of a 2092 form does not override the monthly Medicaid match, so a child who is leaving Medicaid may still be denied based on current Medicaid enrollment (depending on when the application is received relative to the end-date of Medicaid coverage).

IV. Immediate Opportunities

The next three sections of the report outline the MAXIMUS recommendations targeted to meeting one or more of the study's primary goals:

- *Reduce the time it takes to process an application and enroll an eligible child ("Timeliness")*
- *Facilitate enrollment in the right program ("Program Fit")*
- *Reduce the chances of a break in coverage for a child who is moving from Medicaid to MediKids, Healthy Kids, or Title XXI CMSN ("Gap in Coverage")*

The recommendations are grouped in the order in which we believe they can be feasibly implemented, starting with those that will require relatively little lead-time or planning to put in place. For each recommendation, we summarize the relevant issue, explain the recommendation, identify the entity or entities that will be affected, and show how it addresses one or more of the primary goals. Consistent with the study's scope, none of the recommendations include a cost-benefit analysis or estimated impact on program budgets.

Recommendation #1: Change the Medicaid Screen to Count Social Security Income

Relevant Issue. As many as one-third of all KidCare referrals to DCF are denied and sent back to DHACS in the disposition file. (This figure does not include children referred to DCF who are already enrolled in Medicaid and therefore do not progress any further in the eligibility determination process.) Many of these "false positive" referrals eventually result in enrollment in CMSN, MediKids, or Healthy Kids. Children who are unnecessarily referred to DCF take longer to complete the process and also represent additional work and cost at DCF.

Explanation. While MAXIMUS appreciates the reasoning behind a Medicaid screen that errs on the side of too many referrals, we believe the data support a simple change that could significantly reduce the number of false positive referrals without compromising the federal mandate to identify every child who is a reasonable candidate for Medicaid.

In general, we believe the Medicaid screen is appropriate. There is one design element, however, that is overly cautious and out of keeping with the program's general approach to applicant attestation. Even though Social Security income is counted in determining eligibility for Title XXI and Medicaid, the screen disregards it out of DCF

concern that some families will not understand the difference between countable Social Security income and disregarded SSI income. In that theoretical scenario, a family that erroneously lists SSI income in the "Social Security" column would have an artificially high FPL and miss out on the chance to be reviewed for Medicaid.

We believe this approach should be changed for two reasons: the application is self-attested in every respect except non-citizen documentation, and there is no reason to assume that one specific aspect of the application is sufficiently confusing to compromise its integrity; and CHAS data over a recent six month period show that almost two-thirds of the "false positive" DCF referrals involved families that reported social security income.

In the application's income section, there are two separate and clearly marked columns for "Social Security" and "SSI" income. There is no inherent reason to assume that families regularly confuse one source of income for the other. More to the point, disregarding countable social security income based on the fear that some families may be confused is both an unreliable strategy for determining eligibility and one that is inconsistent with the program's general conviction that families can be trusted to fill out the application truthfully and correctly.

MAXIMUS believes that if the Medicaid screen within CHAS were amended to count social security income, rather than disregard it, more than half of the false positive DCF referrals would be eliminated without negatively affecting the screen's basic integrity or accuracy.

Affected entities. DCF, FHKC, and DHACS (FHKC's third party administrator).

Impact on Primary Goals. Reducing the number of false positive referrals will lessen the time it takes to process those applications ("Timeliness") and provide a more reliable basis for referring children to DCF for Medicaid evaluation ("Program Fit").

Recommendation #2: Do Not Make the State Employee Match a Pre-Condition of Eligibility

Relevant Issue. Federal law precludes Title XXI eligibility for dependents of workers who receive their insurance benefits from a state agency. In Florida, this means that children of state employees (except those who fit the "Other Personnel Services" category) are ineligible for the non-Medicaid Title XXI programs.

While the federal government has given states considerable leeway in how they screen for state employee status, Florida has chosen a rigorous method that makes the state employee match a critical step in the Title XXI eligibility determination process. Because comparatively few KidCare applications involve a state employee, this approach essentially means that thousands of applications are unnecessarily held up each month for as long as an extra four weeks.

The numbers for the February 2002 state employee match are instructive. Over 800,000 records were matched against the Banking and Finance database and fewer than 4,000 "hits" were registered, most of which were for inactive applications (DHACS does not purge its database of old records). Even more important, only 216 of the "hits" were associated with new applicants or less than 2% of the new applications for that month. To put it another way, over 98% of the new applications were held up to find the 2% that were actually affected by the state employee match. Some of those needlessly pended applications were associated with "false positive" DCF referrals that would otherwise have been able to proceed directly to a Title XXI eligibility determination but instead had to wait for the state employee match to occur.

Explanation. MAXIMUS agrees that a monthly match is a reasonable approach to identifying applicants and Title XXI enrollees who do not qualify based on state employee status. However, we do not believe that the match should be a pre-requisite to completion of the Title XXI eligibility determination process for two reasons: as long as the match operation is scheduled on a frequent basis, the federal requirement is met; and the very small number of positive "hits" does not warrant such a rigorous strategy.

MAXIMUS recommends that the monthly match process continue under the current timetable. Any new applications that are found to be linked to an active state employee will be disqualified from non-Medicaid Title XXI eligibility and Title XXI enrollees who are matched will be disenrolled at the end of the month in which the match occurred. However, we also recommend that completed applications be allowed to move to the final stage in the eligibility determination process, regardless of whether the state employee match has already occurred. On a practical basis, this may mean that a disproportionately tiny number of ineligible children may receive one month of Title XXI benefits, but we believe this is a small price to pay to expedite the processing of thousands of applications that are unnecessarily stalled each month under the current strategy.

We also recognize that making this change will not have the desired impact so long as the monthly Medicaid match remains a structural impediment to the timely processing of a completed application. The next section of this report addresses that issue.

Affected entities. FHKC and DHACS (FHKC's third party administrator).

Impact on Primary Goals. Changing the state employee match from a required step in the eligibility determination process to a regularly-scheduled program integrity strategy will reduce the time it takes to process a completed application, in some cases by almost a month ("Timeliness").

Recommendation #3: Add Health Status and Immigration Information to the Passive Renewal Notice

Relevant Issues. While the KidCare application provides a way for a family to initiate the CMSN screening process, the Title XXI renewal process does not offer this opportunity. This means that if a child's health status turns significantly worse after the initial Title XXI

eligibility determination, there is no assurance that fact will be communicated to CMSN by DHACS.

In addition, the renewal form does not invite a family with a non-qualified non-citizen child to update obsolete or inaccurate immigration documentation.

Explanation. A child who is initially and properly enrolled in Healthy Kids or MediKids and later experiences a negative and long-term change in health status may be referred to CMSN by the child's health plan or physician. An additional CMSN referral opportunity should be instituted within the context of the renewal process. Just as the application gives families the chance to identify children with special health care needs, we believe the passive renewal process should do that as well.

It should take very little time and effort to change the passive renewal form to add a health status question and provide a means of transmitting affirmative responses through the current electronic interface with the TEARS system.

If a family has obtained immigration documentation that could make a child eligible for the Title XXI subsidy or Medicaid, that information could be requested and retrieved during renewal as well. The renewal form should be modified to solicit updated immigration documentation from families with a non-qualified non-citizen child or from families where a child's citizenship status is still unknown.

Affected entities. CMSN, FHKC, and DHACS (FHKC's third party administrator).

Impact on Primary Goals. Adding a health status question to the passive renewal form will provide an additional and recurring means of ensuring that children with special health care needs are screened for enrollment in CMSN ("Program Fit"). This will be beneficial both to the affected families, since CMSN is designed to meet the unique needs of chronically ill or disabled children, and the health plans whose actuarial assumptions are predicated on a member base that is relatively healthy. Requesting updated immigration documentation from certain immigrant families will ensure that children who are newly eligible for Medicaid or the Title XXI subsidy will not be denied or placed on waiting lists ("Program Fit").

Recommendation #4: Maintain the Title XXI Continuous Eligibility Period for Families that Self-Report Changes in Income or Household Size

Relevant Issue. When a Title XXI family reports a change in income that falls within the Medicaid screening parameters, the enrolled children are referred to DCF. This occurs even though Title XXI eligibility is continuous for six months in accordance with the KidCare statute.

Explanation. One of the most beneficial consequences of the federal SCHIP legislation has been a wholesale embrace by states of defined periods of continuous eligibility. When a state takes this approach, it commits to a specific period of eligibility, regardless of an intervening change in family size or income. This is beneficial because it

promotes continuity of care, facilitates preventive care, and cultivates the concept of a "medical home."

Florida KidCare has already demonstrated its commitment to the virtues of continuous eligibility in the way it treats children who experience a birth date that would otherwise initiate eligibility for a different program. For instance, one-year-olds from families with incomes between 133% and 200% FPL remain in Medicaid until they reach the 12-month anniversary of their coverage, even though they are technically eligible for MediKids.

While the federal legislation is crystal clear on the need to screen new applicants and renewing members for potential Medicaid eligibility, it is equally clear that this requirement does not extend to a change in family status that occurs during a defined period of continuous eligibility. MAXIMUS believes that the health benefits of continuous eligibility are sufficiently compelling that this policy should be enforced across the board.

Affected entities. DCF, AHCA, CMSN, FHKC, and DHACS (FHKC's third party administrator).

Impact on Primary Goals. Maintaining six months of continuous eligibility for non-Medicaid Title XXI families that experience a downward change in FPL will provide continuity of coverage within MediKids, Healthy Kids, and Title XXI CMSN ("Program Fit").

Recommendation #5: Electronically Transmit the MediKids Provider Choice File on a Weekly Basis and Permit New Enrollees to be Added to the Supplemental File

Relevant Issue. Unlike Healthy Kids or Title XXI CMSN, MediKids has an additional step that is a pre-requisite to an eligibility determination: selection or assignment of a health plan or MediPass provider. Even if an application is complete in every other respect---including the monthly matches---it cannot proceed to the final stage until the MediKids Provider Choice file is downloaded and matched against the application.

ACS sends the Provider Choice file to DHACS on the first and second Friday of each month and the third Friday when there are five Saturdays in the month. This means that any family that completes the provider choice process---either voluntarily or through assignment by an AHCA staff-member---in the third or fourth week of the month will have coverage delayed for an additional month because the provider choice data is not available to DHACS and even if it were, new enrollees may not be added to the supplemental enrollment file. In addition, if a family failed to include a $15 payment with the KidCare application, DHACS would be unable to bill the family until the Provider Choice file is received, potentially delaying coverage for an additional month as well.

Explanation. MAXIMUS recommends that the MediKids Provider Choice file transfer be moved to a weekly schedule so that children whose provider choice occurs in the third or fourth weeks of the month have the opportunity of being added to the MediKids supplemental enrollment file for coverage beginning the first day of the next month and

premium bills for those families can be generated promptly. We also believe that children who are determined eligible for MediKids after "Month End Processing" should be added to the MediKids supplemental enrollment file.

Weekly transmission of the provider choice file will also facilitate more timely generation of premium bills for families who fail to include payments with their applications, which may also enable some children to begin coverage at an earlier date (assuming a payment is promptly made).

Affected entities. AHCA, FHKC, DHACS (FHKC's third party administrator), and ACS (as the entity under contract to AHCA).

Impact on Primary Goals. Adopting a weekly schedule for transmission of the MediKids Provider Choice file and including new enrollees in the supplemental MediKids enrollment file will enable some children to begin coverage in MediKids a month earlier, including children who are moving from Medicaid to MediKids as the result of the Medicaid re-determination process ("Timeliness" and "Gap in Coverage").

Recommendation #6: Electronically Transmit All Available Sibling Information to DCF

Relevant Issue. When DHACS refers a child to DCF, it does not always transmit all available application information. If there are siblings listed on the application who do not qualify for Medicaid on the basis of age, for instance, the information associated with those siblings is not transmitted in the data file to KISS. This means that DCF staff must contact the family to request information that has already been provided on the application. This information is needed so that DCF can properly determine family size.

In addition, when a family submits an application to add one or more children to an existing KidCare account, and this action results in a referral to DCF, CHAS is not programmed to include demographic data about the current KidCare siblings within the referral file, information that is also needed to calculate family size.

Explanation. To aid in the timely processing of children referred to DCF, all available sibling information should be included in the referral file so that DCF staff can more accurately determine the number of family-members living within the household without asking for data that was previously provided on the KidCare application.

Affected entities. AHCA, FHKC, DHACS (FHKC's third party administrator), and ACS (as the entity under contract to AHCA).

Impact on Primary Goals. Giving DCF additional information to help determine family size will speed the processing of any application that includes siblings who are included in the CHAS database ("Timeliness").

V. Short-Term Opportunities

The recommendations included in this section are those that we believe can be put in place over a six to eight month period. The primary factors affecting the actual development and implementation time will be programming and system changes, training, and administrative issues such as contract or budget amendments.

The first two recommendations in this section are presented as solutions that could be implemented prior to the more comprehensive approach described in Section VI. It is important to emphasize that we are not suggesting that Recommendations #7 and #8 be implemented permanently. Rather, we believe they offer an attractive alternative to the present environment. But we also believe that once a long-term functional interface is established between the major KidCare eligibility systems, Recommendations #7 and #8 will be obsolete.

Recommendation #7: Mitigate the Impact of the Current Monthly Medicaid Match Strategy

Relevant Issue. While from a strictly logical standpoint, it may seem implausible that a family with children already receiving Medicaid benefits would submit a KidCare application, it is not an uncommon occurrence. There are a number of explanations for why this happens:

- Effective outreach campaigns sometimes prompt responses from families who do not need the services
- Some families are attracted to the idea of sharing the cost of their children's coverage and therefore wish to switch from Medicaid to Healthy Kids or MediKids
- Other families may be attracted to a commercial insurance model, such as Healthy Kids, as opposed to the public assistance image normally associated with Medicaid

Regardless of the reason, tens of thousands of children already enrolled in Medicaid apply each year to KidCare. And while it is a less common occurrence, there are also situations where children already enrolled in MediKids or Healthy Kids subsequently enroll in Medicaid, usually in connection with an adverse change in income and a family's desire to receive other benefits such as Food Stamps or cash assistance.

For these reasons, the KidCare partners had to establish a reliable methodology for identifying and disenrolling Title XXI children who are also enrolled in Medicaid and disqualifying from Title XXI consideration children who are currently receiving Medicaid benefits or are slated to receive them the following month. The approach that was chosen is a reasonable one: a monthly match of the entire CHAS database with the Medicaid enrollment database contained within FMMIS. Like the state employee match, going through the monthly Medicaid match is a pre-requisite to a Title XXI eligibility determination, meaning that many children each month must wait for their coverage to begin because their applications were data-entered shortly after the most recent monthly Medicaid match.

The monthly match operations were consistently identified as the most obvious impediment to timely processing of completed applications. In the prior section, we suggest changing the state employee match from an eligibility determination condition to a program integrity strategy. As a complementary recommendation, we believe the KidCare partners must agree to a plan for screening KidCare applicants for their Medicaid status that does not unnecessarily postpone the consideration of thousands of completed applications for as long as an additional month.

This does not mean eliminating the current monthly match. It will continue to be needed to identify children who are simultaneously enrolled in Medicaid and a non-Medicaid Title XXI program. Rather, the monthly match should not be a pre-requisite to an eligibility determination.

Moving to a different strategy will also have a beneficial impact on the Medicaid screen-and-refer operation, since DCF estimates that around 14% of DHACS referrals involve children already enrolled in Medicaid. A plan that identifies those children prior to a DCF referral would save time at DCF and lead to faster completion of those applications.

Explanation. Through our interviews and review of relevant background information, MAXIMUS identified three ways of screening new applicants for current Medicaid status without holding up the progress of those applications. They are presented in order of desirability, starting with the most appealing approach. An important caveat, however: we cannot assure the technical or operational feasibility of any of the recommendations as ACS declined our request to provide needed technical information regarding their system and business processes.

While we believe each approach is feasible, given a sufficient level of cooperation between DHACS and ACS, we also recognize the sensitivities that arise when firms that compete with one another are asked to exchange information regarding their proprietary systems. Therefore, we believe the first step is for AHCA and FHKC to agree on the operational objectives and then direct their respective contractors to reach agreement on the best technical way to achieve the objectives.

The three options are similar in that each involves a data match against FMMIS using the same criteria as currently employed with one important exception: the match should ignore children currently enrolled in Medicaid whose coverage end-date is the end of the current or following month. Because the current match operation is, in effect, a "snapshot in time," it does not disregard a child whose Medicaid end-date is beyond the last day of the month in which the match occurs.

- *Option #1: Real-time lookup.* The best solution, and our principal recommendation, is a "real-time" online connection between CHAS and FMMIS. After newly entered application data is downloaded into CHAS, the system would match the new data against FMMIS to identify children currently enrolled in Medicaid or slated to be the following month. Children who are matched would proceed directly to a denial of Title XXI eligibility, regardless of other missing

information. Those who are not matched would be cleared for an eligibility determination once the application is deemed complete. CHAS could also be modified to make an additional "real-time" pass against FMMIS for each application that is otherwise complete and ready for a definitive Title XXI eligibility determination.

Because this is a match that occurs at least daily and in "real-time," it will eliminate referrals to DCF of children who are already receiving Medicaid benefits, provided the match is done prior to Medicaid screening within the daily processing hierarchy.

The online connection would not have to be ongoing and persistent; it would only have to be established once or twice a day, following the receipt of an electronic file from the data entry subcontractor. Current Virtual Private Network (VNP) technology makes such a connection both feasible and cost-effective, given the right network set-ups on each end. More information about VPN technology is found in Section VI of this report.

- *Option #2: Weekly incremental matches.* Following the monthly comprehensive match with FMMIS, DHACS would send incremental files to ACS at least once a week containing the data entered since the prior match. This incremental data would be matched against FMMIS. Like the "real-time" scenario, children who are matched would proceed directly to a denial of Title XXI eligibility, regardless of other missing information. Those who are not matched would be cleared for an eligibility determination once the application is deemed complete.

  This alternative is not as attractive as Option #1 for three reasons:

  - It will not reliably eliminate unnecessary referrals to DCF because any applications that are data entered between the weekly incremental matches will be screened and sent on to DCF as needed
  - A completed application will be pended for up to four business days while it waits for the next weekly or monthly match
  - It does accommodate an additional "real-time" pass against FMMIS for each application that is otherwise complete and ready for a definitive Title XXI eligibility determination

- *Option #3: "Real-time" hits against the old match file.* Under the current approach, DHACS sends a comprehensive electronic file to ACS at the beginning of each month, and ACS matches the DHACS file against FMMIS and sends a "results" file back to DHACS. This option reverses that procedure, with ACS sending a subset of the FMMIS data to DHACS on a monthly basis. This file would be retained at DHACS and used to screen new applications on a daily basis, as they are downloaded into CHAS. Like the other two options, children who are matched would proceed directly to a denial of Title XXI eligibility, regardless of

other missing information. Those who are not matched would be cleared for an eligibility determination once the application is deemed complete.

The main comparative disadvantage of this option is the static nature of the data in the match file, which will become less reliable as the month progresses.

The relative advantages and disadvantages of Options #2 and #3 make them roughly comparable in terms of attractiveness. We ordered them in this way, however, because we believe that switching the file transfer protocols, with DHACS matching against FMMIS data instead of the reverse, will be viewed as operationally unattractive by several affected entities.

Affected entities. DCF, FHKC, AHCA, DHACS (FHKC's third party administrator), and ACS (as the entity under contract to AHCA).

Impact on Primary Goals. Removing the monthly Medicaid match as an impediment to the progress of a completed application will reduce processing time, in some cases by almost a month ("Timeliness"). Taking into consideration the impact of the Medicaid end-date will facilitate positive Title XXI eligibility determinations for some children leaving Medicaid ("Gap in Coverage"). Avoiding unnecessary referrals to DCF for children already receiving Medicaid benefits will cut the workload at DCF and ensure that Medicaid coverage is not affected by an irrelevant KidCare application ("Program Fit").

Recommendation #8: Implement an Automated Referral Process for Children Leaving Medicaid

Relevant Issue. The transition of children from Medicaid to one of the non-Medicaid Title XXI programs is difficult to manage and gaps in coverage of one or two months are very common. This presents serious risks for families with children who have special health care needs or are recovering from an illness or injury. The temporary loss of coverage for children in transition is the most serious consumer issue currently facing the KidCare program and the one most in need of a reliable and appropriate solution.

As previously described, the 2092 form is currently used to help move children from Medicaid to one of the non-Medicaid Title XXI programs. The form's intent is to prevent an unnecessary referral by DHACS back to DCF and ensure that the child's current enrollment does not block a Title XXI eligibility determination. However, because it is a paper form that is manually completed and that also relies in some circumstances on specific family behavior, we believe that an operational strategy built around the 2092 form is unreliable and too costly in terms of time and effort.

More importantly, the fact that gaps in coverage continue to occur on a persistent basis is persuasive evidence that an alternative solution is needed. Finally, the lack of consensus between DCF and FHKC regarding the handling and processing of 2092 forms also points to the need for a different plan.

Explanation. MAXIMUS recommends the development and deployment of an electronic file exchange between DCF and DHACS to specifically facilitate the transition of children leaving Medicaid to Healthy Kids, MediKids, or Title XXI CMS. Specifically, we suggest that, on a weekly basis, DCF produce and send to DHACS an incremental file of Medicaid children who have been newly declared ineligible on the basis of income. This file should include the end-date of coverage for each child.

The manner in which DHACS handles these referrals will depend on whether a child originally became eligible for Medicaid through a KidCare application (and therefore is already included in the CHAS database) or a Request for Assistance (in which case a new record would need to be created in CHAS).

For children whose families originally submitted a KidCare application, a DCF referral would be treated in a manner similar to the renewal process. DHACS would send the child's family a form containing the relevant eligibility information as currently shown in CHAS and the family could either correct it or confirm it by declining to respond.

While MAXIMUS believes that children not already listed in CHAS should be helped through the application process, there are some significant operational and system hurdles to doing so. The first step in moving these children toward Title XXI eligibility is receiving a completed and signed application. The second step is ensuring that once an application is received, is does not prompt a DCF referral and also does not result in an ineligibility finding due to current enrollment in Medicaid.

We believe there are three alternatives for children who have been denied Medicaid on the basis of income and who are not known to the CHAS system. Unfortunately, the most desirable approach, which is listed first, is also the most complex:

- Create an initial record in CHAS using the data contained in the DCF referral file; prompt CHAS to send the family an application or a comprehensive missing information letter that includes a signature line; and ensure that when the application is received, the normal Medicaid screening and match processes are overridden.
- Import the non-KidCare children into a separate database at DHACS that can be used to send the families a KidCare application, either from DHACS or the DOH contractor that is currently charged with this responsibility.
- Do not include these non-KidCare children in the DCF file; rather, maintain the status quo for the children (meaning that Public Assistance Specialists would continue to provide an application and a 2092 form).

Before deciding which approach to pursue, we believe the KidCare partners should determine the comparative number of children leaving Medicaid who did not originally qualify through a KidCare application. Based on this information and an analysis of the operational difficulties associated with the first and second options, we believe a reasonable and informed choice can be made.

Affected entities. DCF, FHKC, and DHACS (FHKC's third party administrator).

Impact on Primary Goals. An automated alternative to the 2092 form will create a faster, more efficient, and more reliable way of moving children off Medicaid and into Healthy Kids, MediKids, and Title XXI CMSN ("Gap in Coverage" and "Timeliness").

Recommendation #9: Solicit Missing Information by Phone

Relevant Issue. Around a third of all applications arrive at DHACS sufficiently incomplete to preclude an eligibility determination. These applications are pended until the required items are received. Depending on how long it takes a missing information letter to arrive and the family to respond, coverage can be delayed by a month or longer, depending on when in the month the material is received.

Except for a missing signature or immigration documentation, each type of missing information that is a pre-requisite to an eligibility determination can be obtained over the telephone. It is axiomatic that collecting non-written information over the phone is preferable to mailing it because it moves an application to the completed stage faster. This is why DCF Public Assistance Specialists initially solicit missing information by phone and then follow up with letters.

In contrast to DCF, the default means of collecting missing information at DHACS is through a system-generated form letter. When CHAS detects that an application lacks one or more critical data elements, it produces one or more form letters asking for the missing information. The virtue of the process is its reliability and automation; its principal disadvantage is the time it takes for a missing information letter to be received. Additional time is lost when a family forgets or waits to answer the letter.

Explanation. MAXIMUS recommends that, prior to sending a missing information letter, one attempt be made to collect the information by phone by calling each number listed on the application. If that effort is unsuccessful, then the letter should be sent.

For this recommendation to be implemented, CHAS should be changed as follows:

- After newly entered application data is downloaded into CHAS, a report should be produced listing all families lacking critical eligibility data that can be solicited by phone
- Appropriately trained staff make one attempt to contact each family; following each attempt, the application information is either updated or the record is marked as still incomplete following the phone contact
- CHAS generates missing information letters for all families that are shown to still lack the required information

Affected entities. FHKC and DHACS (FHKC's third party administrator).

Impact on Primary Goals. Collecting information by phone will lead to faster eligibility determinations, which will allow some children to receive coverage sooner ("Timeliness").

Recommendation #10: Re-engineer the CMSN Eligibility Determination Process

Relevant Issue. When a child is referred to the CMSN program for health status screening, a DOH clinician applies a multi-tiered screening tool. Most of the questions in the tool rely on responses to questions that do not require additional medical verification. Only in unusual cases does a DOH nurse review medical records or rely on a physician exam prior to making a decision. Almost 85% of children who are referred to CMSN on the basis of the single application health status question are denied CMSN eligibility.

There are three drawbacks to the current process: the results can be unpredictable and varied among DOH regional staff, given the clinical judgment that is inherent in the process; it can take as long as three weeks to reach a final determination; and a considerable amount of effort is expended reviewing "false positive" referrals.

In our interview with CMSN executive management, a strong preference was expressed for an alternative approach that could take less time and effort and be less susceptible to individual clinical interpretation. Based on feedback they previously received from the Institute for Child Health Policy, CMSN management believes that a multi-question health-status screening tool administered at the family level is the best strategy.

Explanation. MAXIMUS recommends that the KidCare application's child-specific health status question be eliminated in favor of a multi-question test that is applied at the family level to all applicant children.

We believe that a separate section should be added to the application specifically targeted to families who have at least one child with a long-term medical or developmental condition or disability. The introduction to this section should be suitable to a low-literate audience and be designed to avoid creating a barrier for families who might view the questions as intimidating or frightening.

The content and number of the questions is outside of this report's scope. From a practical standpoint, however, we believe that space limitations preclude more than five simple "yes/no" questions. Any "yes" response would apply to one or more applicant children, although the children would not be identified on the application in relation to the questions.

Any application with at least one "yes" response would generate a family referral to CMSN via the CHAS/TEARS interface. The referral would contain contact information for the family, the names of all applicant children, and the "yes/no" responses to each question. CMSN clinical staff would follow up with each family to determine which child (or children) is associated with the affirmative responses and, based on the number of "yes" responses, a determination of CMSN eligibility is made. Consistent with the current process, CMSN will

respond to each referral with a disposition record, indicating which child or children qualified for CMSN services, and DHACS will use that information to construct the monthly Title XXI CMSN enrollment file.

Consistent with recommendation #3 in the prior section, we are also recommending that the multi-question screening tool be added to the passive renewal form.

Affected entities. CMSN, FHKC, and DHACS (FHKC's third party administrator).

Impact on Primary Goals. Adopting a more reliable and efficient means of screening children for CMSN eligibility will reduce the number of "false positive" referrals and improve the program's ability to make correct determinations on a faster basis ("Program Fit" and "Timeliness").

Recommendation #11: Improve the Automated Link between CMSN and DHACS

Relevant Issue. When a child qualifies for Medicaid at DCF and also is confirmed eligible for CMSN by a DOH regional clinician, a manual rather than automated referral process normally occurs. If a clinician knows a particular child is eligible for Medicaid, the family may be counseled to choose CMSN as the health plan. If the family does not follow this advice and chooses a Medicaid HMO or MediPass as its Medicaid provider, there will be a mismatch between the family's needs and the program design. In addition, if CMSN is unaware that a special needs child has qualified for Medicaid, the counseling will be delayed or may never occur.

This process, which is labor-intensive for CMSN, is in marked contrast to the Title XXI process, which is largely automated through the CHAS/TEARS interface. It is also an unreliable way of helping to guide a child into the most medically appropriate health plan choice.

Explanation. MAXIMUS recommends that a Medicaid referral disposition flag be added to the CHAS/TEARS interface data layout. For each child who is referred to CMSN on the basis of the family's response to the health status question, and is also referred to DCF for possible Medicaid eligibility, this flag would allow CMSN to track the status of the DCF referral. If the flag ultimately indicates Medicaid eligibility, then CMSN can ensure timely follow-up with the family.

Affected entities. DHACS, FHKC (as the organization holding the DHACS contract), CMSN, and DCF.

Impact on Primary Goals. This system change will improve the chances that a child who qualifies for Medicaid and CMSN will not mistakenly enroll in MediPass or a Medicaid HMO ("Program Fit").

Recommendation #12: Make the Child Social Security Number (SSN) a Required Data Element

Relevant Issue. Until last August, there was a curious disconnect between the federal application rules for Medicaid and state-designed SCHIP programs. While federal guidelines require disclosure of a Medicaid applicant's SSN (including Medicaid expansions under Title XXI), the original SCHIP rules stipulated that a child's SSN could only be solicited on a voluntary basis.

This presented an operational quandary to states that were trying to design simple and seamless joint eligibility determination processes and it also complicated the integrity of automated processes that rely on common unique identifiers across multiple databases. The final SCHIP rules, however, give states the option of requiring SSNs for applicant children under a state-designed SCHIP program.

Several of the most significant recommendations in this report depend on reliable automated data links between DCF systems and CHAS. Since around 15% of KidCare applications are submitted with the child SSNs left blank, it is clear that highly accurate data links cannot be established for the entire applicant population. In addition, the application of any child lacking a SSN will be pended at DCF if the child appears to be potentially eligible for Medicaid, causing further delay.

While some advocacy organizations have traditionally resisted the idea of requiring SSNs for applicant children, we believe that this opposition is receding in the face of the family and programmatic benefits that accrue from requiring it.

Explanation. Language should be added to the informational brochure indicating that SSNs are required for each applicant child. To lessen the likelihood that this requirement will alienate or frighten some families, a consumer-related context should be provided for this requirement. The most obvious context would be that provision of the SSN enables the application to be processed faster.

DHACS will also have to modify CHAS to add the applicant's SSN to the list of items that are a pre-requisite to a Title XXI eligibility determination. A missing information letter should be produced for those applications that lack an applicant child's SSN.

Affected entities. DCF, AHCA, FHKC, DHACS (FHKC's third party administrator), and ACS (as the entity holding the AHCA contract).

Impact on Primary Goals. Making a child's SSN a required item will expedite the processing of a Medicaid referral ("Timeliness"), and improve the feasibility of the automated data interfaces proposed in Recommendations #7 ("Timeliness" and "Program Fit") and #8 ("Gap in Coverage").

Recommendation #13: Application Changes

In addition to the CMSN application modification proposed in Recommendation #10, we also believe that the major program goals can be advanced through two other application changes. While these changes will require additional space on the application, we believe they can be accommodated through deletion of the child-specific health status questions and other data elements that are desirable but not essential. The next time the KidCare partners convene an Application Workgroup, we recommend the following changes (which are described separately because each has a different rationale):

Recommendation #13(a): Application Change---Collect Information for Non-Applicant Children

Relevant Issue. The current application does not adequately account for the differences in how Medicaid and Title XXI calculate family size. While the "Household Size" question on the second page of the application meets the Title XXI needs, it is insufficient for Medicaid because that program determines which non-applicant children to count based on their age and relationship to the parent(s) or guardian(s) listed at the top of the application.

Whenever there is a discrepancy between the number of applicant children listed on the first page of the application and the total number of children in the household as shown on the second page, DCF personnel must contact the family to obtain more information about the non-applicant children. Until that information is received, the application cannot proceed to a final eligibility determination. In addition, without this information, the Medicaid screen within CHAS cannot accurately account for family size when non-applicant children are present in the household.

Explanation. MAXIMUS recommends that an additional question be added to collect the following information for each non-applicant child living in the household: name, birth date, and relationship to the parent(s) or guardian(s). Specifically, we recommend that enough space be provided to collect this information for two children with instructions to add an additional sheet for other non-applicant children.

Concurrent with this change to the application, the Medicaid screen should be modified to disregard non-applicant children who are not the siblings of applicant children or who are too old to be included in the family size. In addition, CHAS would have to be modified to store this information.

Affected entities. DCF, FHKC, and DHACS (FHKC's third party administrator).

Impact on Primary Goals. Collecting this information at the time of the original application will speed the processing of certain Medicaid referrals and improve the accuracy of the Medicaid screen ("Timeliness," "Program Fit").

Recommendation #13(b): Application Change---Request Immigration Documentation at the Time of Application

Relevant Issue. On an annual basis, tens of thousands of KidCare applications are held up because of missing immigration documentation. For instance, between July and December, 2001, 27,556 applications required immigration documentation, or 16% of the total received during that time period. These figures do not include those applications that passed the Medicaid screen and prompted a subsequent immigration documentation request at DCF.

The relatively high number of pended applications for this reason is not surprising since neither the application nor the informational brochure ask for immigration documentation for children who are marked as non-citizens.

Explanation. It is a legal requirement that all non-citizen applicant children be screened for immigration status. This is because a non-citizen child can qualify for the Title XXI subsidy only by meeting specific immigration documentation and length-of-residence requirements.

Because families of non-citizen applicant children will eventually have to produce the necessary documentation, requesting it at the time the original application is submitted will save processing time and result in a less complicated process for the family. We recommend that the following text (or comparable wording) be placed next to the child-specific citizenship question: "If you checked 'no,' please see instructions." In the instructions section of the informational brochure, the immigration documentation requirement should be explained in a way that is clear but also sensitively worded, including an explanation of how the information will and will not be used.

At the same time this change is made, DHACS must ensure that its business processes accommodate the receipt of immigration documentation along with original applications. More precisely, DHACS should arrange for properly trained staff to review the documentation at the time the application is loaded into CHAS, or shortly thereafter, to assure a correct eligibility determination based on immigration status. Because this is a very complicated subject, it cannot be fully automated and must rely on the judgment of individuals who have been thoroughly trained regarding the law's subtleties and complexities.

Affected entities. DCF, FHKC, and DHACS (FHKC's third party administrator).

Impact on Primary Goals. Collecting this information at the time of the original application will expedite the processing of any application that involves non-citizen applicant children ("Timeliness").

Recommendation #14: DHACS Review of Immigration Documentation Should be Accepted for Medicaid Review Purposes

Relevant Issue. Because the current KidCare program design assumes that immigration documentation is not received with a newly submitted application, Medicaid referrals involving non-citizen children require DCF follow-up to obtain the necessary

documentation. On a practical basis, this means that a PAS reviews the written immigration material for any non-citizen child whose family mails in a KidCare application.

However, if Recommendation #13(b) is adopted and the DHACS business processes are changed to request submission of the documentation at the time of application, then DCF review of the material may be duplicative.

Explanation. If DHACS reviews the immigration documentation of non-citizen children prior to their referral to DCF, then a subsequent review at DCF will be costly in terms of time and workload. The principal rationale for this duplication of effort would be the absence of a strategy for holding the FHKC third party administrator accountable for incorrect or inaccurate immigration documentation evaluations.

In our interview with DCF management, they raised a concern regarding the extent to which FHKC's third party administrator can be held accountable for the accuracy of work done in connection with Medicaid. This concern was voiced as we discussed possible ways that duplication of effort between DHACS and DCF could be reduced. The concern was not based on a belief that DHACS is doing an unacceptable job, but rather the fact that DHACS is contractually accountable only to FHKC.

While we appreciate DCF's desire not to be liable in an audit situation for the mistakes of another party, MAXIMUS believes that the current arrangement among the KidCare partners provides sufficient and practical lines of accountability to mitigate this concern. We base this belief on two facts:

- While DCF cannot hold FHKC or DHACS accountable for the accuracy or integrity of its business processes, AHCA has that authority through its delegation to FHKC of the KidCare application processing responsibilities. AHCA's contract with FHKC provides a clear line of accountability between the State and the entity that is ultimately responsible for the third party administrator's performance.
- To ensure that its responsibilities to AHCA and KidCare consumers are fulfilled, FHKC has implemented rigorous performance standards in its new contract with DHACS, including liquidated damages for failure to perform. These performance standards include a minimum 98% accuracy rate for application processing and eligibility determination (which incorporate immigration documentation screening).

Between FHKC's obligations to AHCA and DHACS' rigorous contractual commitments to FHKC, we believe there is a sufficient basis upon which DCF can rely on the integrity of immigration documentation reviews at DHACS. Therefore, MAXIMUS recommends that DCF accept, without further review or examination, the results of immigration documentation reviews that occur at DHACS prior to a Medicaid referral (assuming that Recommendation #13(b) is adopted).

Affected entities. AHCA, DCF, FHKC, and DHACS (FHKC's third party administrator).

Impact on Primary Goals. DCF acceptance of DHACS immigration documentation reviews will prevent duplication of effort, thereby expediting the handling of Medicaid referrals ("Timeliness").

Recommendation #15: Implement a Statewide Online KidCare Application

Relevant Issue. Within the past year, a number of states have implemented interactive online applications for children's Medicaid and state-designed SCHIP programs on a statewide or pilot basis. An FHKC online application micro-pilot project is underway in five counties in collaboration with a group of specially trained community-based organizations (CBOs). The pilot's focus is on improving access to KidCare for special populations and within certain local settings. The micro-pilot is not available to applicant families. Rather, a staff-person from one of the participating CBOs works one-on-one with applicants to enter the application information either at an onsite workstation or through a wireless laptop computer. The project should provide valuable consumer information that will aid in the development and deployment of a statewide, consumer-oriented online application.

Three notable examples of states that have already deployed online systems on a statewide basis are Georgia (peachcare.org), California (healtheapp.org), and Texas (texcarepartnership.com). The online applications in these states are similar in several respects. Each version allows a user to fill out an application by responding to a series of interview-style questions that appear on individual screens. Applicants type data into the screens and some of the electronic fields have data validation to prevent an inaccurate or inappropriate entry. Each version also provides a "real-time" tentative eligibility determination subject to final review once a signed application is received. Finally, each online application offers instructions or Help that is linked to the data being sought on the screen.

The principal differences are associated with program design elements (such as health plan choice or enrollment procedures) and the manner in which the application data is received by the operating agency. The Georgia and California systems allow the application data to be sent electronically to the eligibility determination system. Conversely, the Texas system only stores an applicant's data temporarily. Prior to logging off, an applicant prints a paper copy of the completed application, signs it, and returns it with the required verifications.

The Georgia "PeachCare" application is a particularly relevant example for Florida because it was designed and implemented by DHACS and therefore may involve technology that can be cost-effectively and expeditiously leveraged in Florida.

Explanation. MAXIMUS recommends that an online KidCare application be deployed to permit online entry of application information (including data validation), generation of a tentative eligibility determination, and online submission of data or production of a written application at the family's printer (depending on the preference of the KidCare partners and system or network capabilities). We also recommend that FHKC review the results of its micro-pilot to assess the benefits of going into statewide collaboration with community

agencies. Design and implementation of the online application would be an appropriate follow-up step to FHKC's micro-pilot.

With appropriate data security and information validation procedures, we believe the online submission of data is very attractive because it will reduce or eliminate the need to manually enter application information into the system at DHACS (or its subcontractor), significantly reduce the likelihood of missing information, and provide more instructions and context-sensitive Help than is possible with a written application and informational brochure.

Affected entities. AHCA, DCF, CMSN, FHKC, and DHACS (FHKC's third party administrator).

Impact on Primary Goals. A well-designed, secure, and robust online application will reduce the time it takes to turn application information into useable electronic data and reduce the likelihood of critical missing data elements as well as provide an additional point of access ("Timeliness"). The tentative eligibility determination delivered in "real-time" will give applicants an early understanding of the program(s) for which their child(ren) may qualify. In addition, for children who are leaving Medicaid and who originally applied using the DCF "Request for Assistance," an online application would reduce the likelihood of a gap in coverage because it will be processed more quickly and be less susceptible to missing information ("Gap in Coverage").

Recommendation #16: Handle all KidCare Referrals at the Central Processing Units

Relevant Issue. The way in which DCF handles KidCare referrals is described in Section III(H) of this report. As we note in that section, when a KidCare referral involves a child who has an active case within FLORIDA, the referral is assigned the same unique number as the active case and the application information (as printed from KISS) is sent to the PAS who is already assigned to the case.

The re-assignment of a KidCare referral from a KidCare Central Processing Unit (CPU) to a PAS in a local DCF office occurs for two reasons:

- For security purposes, the FLORIDA system only allows the PAS who is assigned to the case the right to modify it (with a limited number of local back-up options)
- The open case may involve non-Medicaid benefits, such as cash assistance (TANF) or Food Stamps, and the staff in the four KidCare CPUs are not trained to handle those other programs

While these are logical reasons for the current approach, we believe that the time and effort that are expended re-routing a KidCare application to a local office justify the consideration of an alternative approach.

Explanation. MAXIMUS recommends that DCF convene an internal workgroup to develop a plan for handling KidCare referrals involving open cases in FLORIDA within the

appropriate CPU rather than routing them to the Public Assistance Specialists responsible for the original case.

We believe this is a particularly appropriate option for KidCare applications that contain information that is consistent with current case's data. In that situation, we believe that no disruption would occur to any non-Medicaid benefits currently in effect. However, because CPU staff members currently are responsible for investigating discrepancies between application income information and the various income databases, we believe it is possible for Public Assistance Specialists who work within a KidCare CPU to investigate discrepancies between the data in an open FLORIDA case and the information on a KidCare application.

This recommendation is a significant departure from current DCF business process and system protocols. We are making it because the report's scope compels us to identify any opportunities to expedite the processing of all applications, including those involving open FLORIDA cases.

Affected entities. DCF.

Impact on Primary Goals. Handling all KidCare applications within the CPU environment will speed the processing of children whose families already have a case open within FLORIDA ("Timeliness").

VI. Long-Term Opportunities

The first three recommendations in this section are the most important and far-reaching of the report. If they are implemented as a group, they will significantly improve the likelihood of a seamless transition between Medicaid and the non-Medicaid Title XXI programs, virtually eliminate duplication of effort between DCF and the KidCare third party administrator, and speed up the processing time for all KidCare applications, especially those involving children who are currently referred to DCF.

The amount of time it will take to fully implement these changes will depend on a variety of factors, including the technical challenges posed by the integration of significantly different automated systems and the speed with which the KidCare partners can agree on a transition to a dramatically altered operational relationship between DCF and the third party administrator (TPA). The feasibility of these changes will be enhanced if all KidCare partners and contractors implement the VPN technology that is suggested in Recommendation #21.

Because these recommendations may unfold over a number of years, in this section we use the term "third party administrator" and "TPA's system" more frequently than "DHACS" and "CHAS" to avoid an inadvertent suggestion that a particular company or system necessarily have a permanent role to play in the KidCare infrastructure.

If Recommendation #17 is successfully implemented, it will effectively replace Recommendations #7 and #8, which are offered as interim solutions. Recommendation #17 is also a precondition for Recommendations #18 and #19.

Recommendation #17: Create an Automated Data Interface Between FLORIDA and the Third Party Administrator's System

Relevant Issue. Florida KidCare's large application and enrollment volumes, and the differing eligibility rules and business processes associated with the four component programs, mean the system infrastructures at DCF and the FHKC third party administrator bear a disproportionate load in ensuring a smooth and efficient eligibility determination process.

As shown in Section III of this report, the operational and electronic links between the systems work well in some ways and have obvious deficiencies in other respects. The major problems with the current infrastructure are:

- Referrals by DHACS to DCF involve manual duplication of effort. The DHACS data is loaded into KISS and then used by Central Processing Unit staff in hard copy. This means two different individuals type in the application data on separate occasions (one person enters the data into CHAS and another types it into FLORIDA). Disposition of KidCare Medicaid referrals are also manually entered into KISS for transmission back to DHACS.
- The CHAS to KISS to FLORIDA data route (as well as the reverse) is inefficient and wastes time. Because part of it is manual, it is also at risk of data-entry error.
- There is no means of transmitting to DHACS needed electronic data, including Medicaid coverage end-date, for children who are leaving Medicaid for income reasons.

Each of these problems has a direct and negative impact on consumer satisfaction, principally by causing longer processing times (which may delay the start of coverage by one or more months) and gaps in coverage for children moving between Medicaid and Healthy Kids, MediKids, or Title XXI CMSN.

Explanation. The problems outlined above can be mitigated or largely eliminated by creating a secure online data interface between FLORIDA and the third party administrator's automated system, and phasing out the KISS system:

- Duplication of effort is eliminated because data typed into the TPA's system is electronically fed directly into FLORIDA with no manual intervention by DCF staff. Similarly, when a child is approved or denied for Medicaid, that action, which is recorded in FLORIDA, would be sent electronically to CHAS.
- The inherent inefficiency of the CHAS to KISS to FLORIDA data route is entirely eliminated once KISS is phased out.
- A data link between FLORIDA and CHAS would make the 2092 form and the interim approach described in Recommendation #8 obsolete.

Because this recommendation is inherently challenging from a technical and operational standpoint, and because numerous decisions will have to be made as it moves

from an idea to an implementation strategy, we are describing this recommendation at a relatively high conceptual level, focusing only the key decision points.

The first involves the nature of the connection. Given today's Internet and networking environments, MAXIMUS believes the best strategy is a connection through a Virtual Private Network, a solution that is feasible and cost-effective, given the right network and software configurations on both ends. More information about VPN technology is found in Section VI of this report.

Other decision points involve the frequency of the connection, the types of data that are collected and flow between the systems, the business processes to which the data is applied within each system, and the manner in which records are linked between the systems. Each decision will have to be made through a highly collaborative process involving DCF, FHKC, and the third party administrator.

A particularly ambitious approach to this recommendation, and one that MAXIMUS believes offers real long-term consumer and operational value, would involve the implementation of a common technology (we recommend eXtensible Markup Language or "XML") across systems and a shared set of eligibility business rules across the programs. Common business rules do not imply the same eligibility criteria for each program. Instead, they mean that the TPA system would be capable of generating accurate and reliable Medicaid determinations just as FLORIDA would be able to evaluate Title XXI eligibility. While the parameters of the eligibility determination rules can be different (e.g., how the size of a household is calculated), the algorithms governing how those parameters are applied to each program would be common across the systems.

Affected entities. DCF, FHKC, and DHACS (FHKC's third party administrator).

Impact on Primary Goals. A well-designed and secure online interface between the Title XXI and Medicaid systems will speed up processing times and eliminate duplication of effort ("Timeliness"), facilitate the timely transfer of data for children who are moving between programs ("Gap in Coverage"), and provide for a common understanding between operating entities regarding the business process and rules governing each program within the KidCare umbrella ("Program Fit").

Recommendation #18: Permit the Third Party Administrator to Make Medicaid Determinations

Relevant Issue. A bifurcated Medicaid eligibility process that begins at the third party administrator and ends at DCF creates the possibility of multiple missing information letters and other correspondence originating from separate organizations (which may confuse families), and the loss of time associated with "false positive" referrals. It can also cause a negative consumer experience when a family calls the TPA's hotline not realizing that application has been referred to DCF. Similarly, a call to DCF can lead to frustration when Medicaid has been denied and the application has been reactivated at DHACS.

While federal law requires that staff employed by a state agency make all final Medicaid eligibility determinations, the Centers for Medicare and Medicaid Services (CMS) has a flexible policy in how states can meet that requirement.

A prime example of this flexibility is Georgia PeachCare, which also employs DHACS as the Title XXI third party administrator. In Georgia, DHACS is authorized to make Medicaid determinations subject to a *pro forma* ratification by the relevant state agency. This ratification process assumes that the DHACS determination is correct and no additional substantive work by state eligibility workers is necessary. Eligibility information for Medicaid and the state-designed SCHIP program, including start and end-dates, are contained within the same DHACS system, which enables enrollees to move seamlessly from one program to the other in much the same way that MediKids enrollees transparently graduate to Healthy Kids following their fifth birthday.

The integration of Medicaid and Title XXI eligibility and enrollment data within the same system provides other consumer benefits as well. Application processing time is conserved because all critical eligibility information is collected and processed at the same place. The risk of a family becoming confused is reduced because all correspondence and phone contact originates from the same functional entity. And because the DHACS call center staff have access to both Medicaid and SCHIP program data, callers do not have to worry about being referred to a different hotline.

Explanation. MAXIMUS recommends that the Florida KidCare Title XXI State Plan Amendment be changed to allow the FHKC third party administrator to make definitive Medicaid eligibility determinations, including re-determinations, subject to a *pro forma* DCF approval. A favorable Medicaid determination or re-determination would be passed to DCF along with images of the paper forms and that data would be received by FLORIDA, subjected to a perfunctory ratification, and validated within FLORIDA as a *bona fide* Medicaid determination. For families that apply using the KidCare application, this would allow for seamless movement of children between programs and integrated consumer service, particularly in terms of the call center. This approach would also reduce the workload at DCF and end the persistent problem of "false positive" referrals.

This recommendation is predicated on implementation of the secure online data link between FLORIDA and the third party administrator's system, as described in the prior recommendation. It also assumes that the scope of the TPA system would expand to making and continuously tracking Medicaid eligibility determinations in a manner comparable to the Georgia PeachCare program.

During our interview with DCF management, they doubted whether FHKC's third party administrator could be held accountable for the accuracy of work done in connection with Medicaid. That concern is especially relevant within the context of this recommendation because DCF would essentially be asked to validate the entire DHACS eligibility determination apparatus, and not just as it relates to the accuracy and reliability of immigration documentation review.

To reiterate a point made previously in this report, MAXIMUS believes that the current arrangement among the KidCare partners provides sufficient and workable lines of accountability to warrant an arrangement in which the third party administrator is charged with the responsibility of making and tracking Medicaid eligibility determinations. Specifically, we believe FHKC's contract with AHCA and the rigorous performance standards inherent in the new DHACS contract provide a framework within which DCF can feel comfortable.

Affected entities. DCF, FHKC, and DHACS (FHKC's third party administrator).

Impact on Primary Goals. Granting the Title XXI third party administrator the responsibility of making Medicaid eligibility determinations and re-determinations for families who apply through the KidCare application will speed up the process for any child who is currently affected by the DCF referral processes ("Timeliness"), eliminate "false positive" referrals ("Timeliness" and "Program Fit"), and provide a foundation for smooth transitions between all KidCare programs for children who enter the process through a KidCare application ("Gap in Coverage").

Recommendation #19: The Medicaid Re-determination Process Should be Re-Engineered

Relevant Issues. Families whose children are enrolled in KidCare Medicaid must go through a more rigorous re-determination process than families whose children are receiving benefits through Healthy Kids, MediKids, or Title XXI CMSN. Unlike the Title XXI children, a child enrolled in Medicaid loses eligibility if his or her family fails to complete and return to DCF a new application in a timely manner. This new application is required even though the family's basic information is already available in FLORIDA.

A recent Institute for Child Health Policy report showed that Florida's passive re-determination process for its non-Medicaid Title XXI programs results in a much higher level of retention than approaches employed in other states. The passive re-determination process is successful because it does not require additional effort from families whose circumstances have not changed since the last time application information was reported. Families indicate their desire to keep their children enrolled in Healthy Kids, MediKids, or CMSN by continuing to pay the $15 monthly premium.

In Recommendation #18, we propose a major change in program policy that would substantially improve the consumer experience of families who apply for children's health insurance using the KidCare joint application. These benefits will not accrue, however, to families whose children enroll in Medicaid through the DCF "Request for Assistance" form or who go through the traditional DCF re-determination process.

While a secure online data link between FLORIDA and the third party administrator's system will significantly mitigate the risks of a loss in coverage when a child leaves Medicaid, it does not fully address the problem in and of itself. That is because an eligibility determination is still needed, and that cannot occur unless CHAS has the necessary updated

information to make a determination. Recommendation #18 addresses that because a denial of Medicaid eligibility within the TPA's system is immediately followed by a determination of Title XXI eligibility.

But what if a child is not listed in the TPA system because the child's family never submitted a KidCare application? Under the present system, and also under the short-term solutions suggested in Section V, a new KidCare application must be started and the child's Medicaid denial must somehow become known to the third party administrator. Both of these actions take time and because a family action is required (submission of a new application), the process is also susceptible to error or further delay due to missing information. When processing delays occur in connection with a program transition, a gap in coverage is virtually inevitable.

Explanation. The "passive renewal" approach used in Florida's non-Medicaid Title XXI programs is responsible for some of the highest retention SCHIP rates in the country and a high degree of consumer satisfaction. While an identical process will not work with KidCare Medicaid, because of the absence of the $15 monthly premium obligation, we believe the DCF process can be changed to reflect the primary advantage of passive renewal, which is not making a family re-submit information that was previously provided and is still accurate.

There is no Florida legislative requirement mandating the submission of a new application to re-determine eligibility for Medicaid. At the same time, the Florida KidCare Act is clear in its intention that all KidCare programs employ simplified processes for providing and updating eligibility information.

Accordingly, we recommend that DCF revise its KidCare Medicaid re-determination process to eliminate the requirement that a family submit a new application on a periodic basis and also permit simpler means of reporting relevant changes in family circumstances. Specifically, in its periodic re-determination notice, DCF should print the applicable eligibility information as currently stored in FLORIDA. A family would be responsible for responding to this notice by either confirming that the information printed on the re-determination form is still accurate or providing updated information. This could be done through the mail, over the phone, or even online, depending on the feasibility of each approach.

The simplest solution to the transition of non-KidCare applicant children to a non-Medicaid Title XXI program is to give DCF Public Assistance Specialists the power to make Title XXI eligibility determinations. This would, in effect, be the mirror image of allowing the third party administrator to make Medicaid determinations.

There are two similar automated ways that DCF can facilitate a more efficient and timely Title XXI eligibility determination for children leaving Medicaid who are not known to the third party administrator's system:

- FLORIDA sends all needed application information, including family size and income, to the TPA system that then applies the Title XXI eligibility algorithm to the data. However, because Medicaid counts family size differently from the Title XXI programs, a problem will arise for any family that has more children or adults than are reflected within the Medicaid record in FLORIDA. For that reason, CHAS will either have to accept the family size information from FLORIDA "as is" or a missing information letter will be needed to collect household size information that is currently not gathered through the Request for Assistance.
- Develop a turn-key Title XXI eligibility algorithm within FLORIDA that can make a definitive determination that can then be sent electronically to the TPA system. Under this strategy, the updated income information that caused the Medicaid denial would, in turn, precipitate an automatic Title XXI assessment. DCF staff would not need to learn new eligibility standards because the process would be automated within FLORIDA.

Under either scenario, an agreement would have to be reached between DCF and the third party administrator regarding the transmission of application images and/or storage of applications so the Title XXI signature requirement is met. We believe a signature on a Request for Assistance mitigates the need for a new signature on a KidCare application.

An alternative to the automated approaches is empowering Public Assistance Specialists to make Title XXI eligibility determinations. This method poses significant practical problems because the eligibility parameters for Title XIX and Title XXI are different. However, if Recommendation #22 is adopted, then this approach would be much more feasible and worthy of consideration.

Affected entities. DCF, CMSN, FHKC, and DHACS (FHKC's third party administrator).

Impact on Primary Goals. Re-engineering the KidCare Medicaid re-determination process will provide a foundation for higher enrollment retention ("Program Fit") and a smooth and timely transition from Medicaid to Healthy Kids, MediKids, or Title XXI CMSN ("Timeliness" and "Gap in Coverage").

Recommendation #20: Process KidCare Applications in Florida

Relevant Issue. One of the most interesting aspects of the KidCare application processing strategy is the receipt of applications in Florida and their subsequent overnight shipment to the Chicago area, where DHACS is located.

The applications and all related materials, including missing information, are received at Florida post office boxes to create an image for the KidCare consumer of a program that is processed for Florida families in Florida. We concur that this is an important image to preserve, even if it means delaying the process for at least a day so the applications can be sent to a different state.

From a process-flow standpoint, however, this strategy is hard to justify and, because it inserts at least one additional day into the process, does not advance the objective of an efficient and timely processing methodology.

Explanation. While shipping hundreds or thousands of applications from Tallahassee to Lisle, Illinois on a daily basis is inefficient, MAXIMUS agrees that this is a small price to pay to cultivate and maintain a positive public image for the program.

However, if DHACS locates an operation in Florida, perhaps for a call center or some other significant operational component, we recommend that applications be opened, batched, and scanned in Florida.

Affected entities. FHKC and DHACS (FHKC's third party administrator).

Impact on Primary Goals. Physically processing applications in Florida rather than Lisle will save at least a day's worth of processing time for each KidCare application ("Timeliness").

VII. Corollary Issues

This section contains issues and recommendations that are not directly related to eligibility determination but that came to our attention during our interviews and review of written materials. MAXIMUS believes these recommendations are worthy of consideration, either on the basis of their own merit or in connection with an overall effort to change the eligibility determination process to improve consumer satisfaction.

For each recommendation, we summarize the relevant issue, explain the recommendation, identify the entity or entities that will be affected, and categorize it in terms of an implementation timeframe.

Recommendation #21: Adopt Virtual Private Network Technology to Transfer Sensitive Client Information

Relevant Issue. The electronic interfaces that tie together the application processing and eligibility determination procedures among the KidCare partners, contractors, and subcontractors are a mixed bag of file transfer protocols, some of which are secure and others of which do not have the advantage of encryption technology. In addition, each of the protocols involves some degree of manual effort on one or both ends, which makes them susceptible to breakdowns when critical personnel are unavailable.

Unfortunately, the least automated and secure transfer methods are used for the operations that occur most often and involve highly confidential information: the application data that flows from the data input subcontractor to DHACS, the CHAS/KISS interface that facilitates the Medicaid referral process, and the CHAS/TEARS interface used to convey information for children who have special health care needs. Each of these operations relies

on the least secure form of file transfer available on the Internet: unencrypted e-mail attachments.

The security of confidential information related to health insurance or health status is a concern as the effects of the Health Insurance Portability and Accountability Act (HIPAA) are felt in the near future. FHKC is in the final stages of its HIPAA assessment and we know from our interviews with FHKC staff that the security of file transfer protocols will be addressed. Even if HIPAA were not an issue, however, MAXIMUS is concerned whether the current e-mail attachment method would hold up to rigorous scrutiny by a relevant oversight entity.

While we believe that the other methods currently used to move KidCare data are better solutions than e-mail attachments that are manually used to export and import records, in general we believe another solution is available that makes it possible to replace manual operations with automated routines.

This alternative, which MAXIMUS recommends as a replacement for all of the data exchange protocols currently in use, is Virtual Private Network (VPN) technology, sometimes nicknamed "tunneling through the Internet." This approach, which uses the IPSec network protocol, is a more reliable and faster method than those currently in use within the KidCare systems infrastructure. Connections between systems and databases can be accomplished through several mechanisms, which are described below.

A VPN is an extension of a private network that encompasses encapsulated, encrypted, and authenticated links across shared or public networks. VPN connections can provide remote access and routed connections to private networks over the Internet. We know DHACS has the ability to deploy a VPN because it has successfully implemented a VPN connection via the Internet between its office and its call center subcontractor located in another state.

Another advantage to establishing a VPN to link systems is the transparency of the connection from the user's standpoint. Assuming a "real-time" database-to-database implementation, a user could conduct work normally and the only hint that a VPN connection is in place is a slightly longer response time when the "home" system makes a request across the VPN to the other system. The time lag that occurs when one system connects to another can be eliminated via database "replication" (in which a copy of a database is stored on another system), or "data caching" (temporarily keeping recently used information from one database on the other system). From the perspective of technical support staff, the automated integration of databases between systems eliminates the need to manually send and receive files via email, FTP, or password protected websites.

While "real-time" integration is the most desirable approach, MAXIMUS recognizes that other factors may prevent its implementation in the short-term. However, the VPN approach is also clearly preferable in an environment in which data continues to be transferred between systems within individual files. Compared to unencrypted e-mail attachments, a VPN is highly secure. A VPN is amenable to automated approaches in which the data can be

downloaded from the host database and passed to the recipient system on a regular schedule without the need for a technician to manually carry out some of the tasks. Even if a manual approach is taken, the actual means of collecting and sending the files is simpler because it is based on a simple Windows-style "copy-and-paste" operation.

Explanation. To fully realize the benefits of the VPN alternative, the affected systems---CHAS, FLORIDA, FMMIS, TEARS, and KISS (so long as it remains operational)---will need to be modified to perform real-time database calls to other systems. There are two general options for accomplishing this objective that rely on "open" (non-proprietary) standards: the eXtensible Markup Language (XML) or the Open DataBase Connectivity (ODBC) protocol.

As an alternative to a "real-time" database-to-database connection, an on-demand or persistent VPN connection can be used to move data between systems in ANSI formatted text, which is a "flat-file" structure supported by all common database solutions. For example, a CHAS to FLORIDA text-interface would only contain information needed by the other system. The system making the request would locate the text file at a specific location on the other system, copy it, paste it, and import the text data into its own database format. The copy-and-paste part of the operation could be automated or handled by a technician.

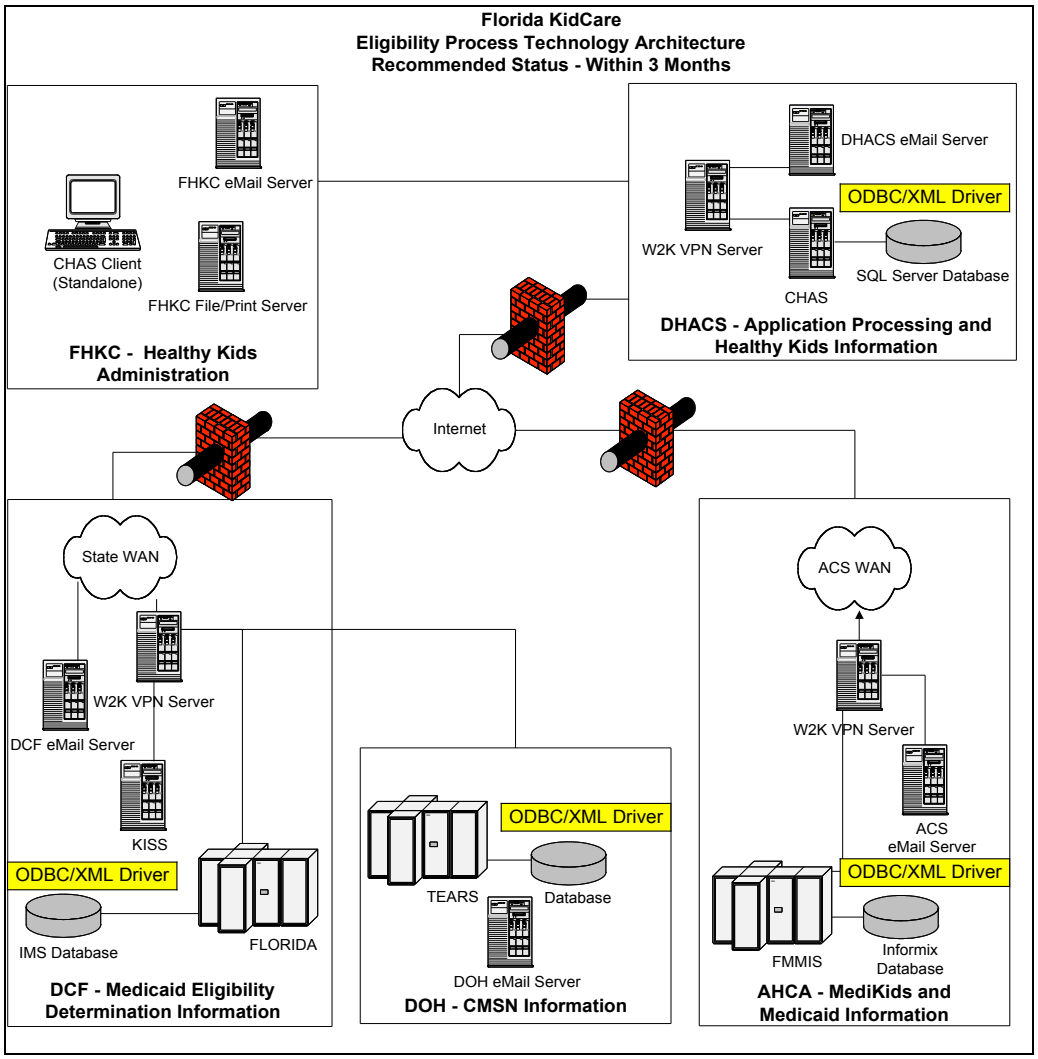
ODBC connectivity to a "mainframe" based non-relational IMS (like FLORIDA) can be accomplished through the use of many ODBC drivers for IMS available from commercial vendors (Computer Associates is one example). XML connectivity to IMS data can be implemented through IBM's XML Toolkit for OS/390.

Other database connectivity standards can be considered (e.g. Java DataBase Connectivity – JDBC), but their speed and scalability may not be optimal in a Microsoft SQL Server environment, which is the database system used by the third party administrator's system.

Another alternative to a "real-time" or "on-demand" interface is to securely exchange the data across a VPN connection using an encrypted File Transfer Protocol (FTP) or some similar transmission protocol.

Data specific to the ACS technical environment was not made available to the MAXIMUS team. It is assumed that this environment is based upon either a Commercial-Off-The-Shelf (COTS) relational database product (e.g. Informix) that includes support for both ODBC and XML, or it is an IBM IMS or DB2 database structure and can be interfaced with the same techniques described above.

The recommended data exchange infrastructure environment for Florida KidCare is depicted in the following illustration.



The illustration depicts the minimal VPN environment utilizing the PPTP (Point-to-Point Tunneling Protocol) in the Windows 2000 (W2K) Server environment. PPTP is a Layer 2 protocol that encapsulates PPP frames in IP datagrams for transmission over the Internet. PPTP can be used for remote access and router-to-router VPN connections. PPTP uses a TCP connection for tunnel maintenance and a modified version of Generic Routing Encapsulation to encapsulate PPP frames for tunneled data.

A more secure, but costly, solution is L2TP/IPSec. L2TP is a combination of PPTP and Layer 2 Forwarding (L2F), and represents the best features of PPTP and L2F. IPSec is a Layer 3 protocol standard that supports the secured transfer of information over an IP internetwork (like the Internet). L2TP encapsulates PPP frames to be sent over IP, X.25, Frame Relay, or ATM networks. When configured to use IP as its datagram transport, L2TP can be used as a tunneling protocol over the Internet. L2TP over IP utilizes UDP and a series of L2TP messages for tunnel maintenance. In Windows 2000, IPSec Encapsulating Security Payload (ESP) is used to encrypt the L2TP packet. This is known as L2TP/IPSec.

The essential differences between PPTP and L2TP/IPSec are:

- *Cost:* L2TP/IPSec requires a "certificate server" while PPTP does not.
- *Security:* L2TP/IPSec is more secure because it requires user-level authentication and computer-level authentication using certificates while PPTP requires only user-level authentication.

While L2TP/IPSec ensures a more secure environment, it requires Windows XP or Windows 2000. Earlier versions of Windows (with Dial-Up Networking 1.3 Performance and Security Update) cannot use L2TP protocol, IPSec, and certificates capability. Finally, if any of the KidCare systems use Network Address Translation (NAT) technology, PPTP will have to be selected since L2TP/IPSec is not NAT-translatable.

Affected entities. DCF, CMSN, AHCA, FHKC, DHACS (FHKC's third party administrator), and ACS (as the entity holding the AHCA contract).

Implementation Timeframe. VPN technology is widely used in many corporate and government environments. MAXIMUS believes this recommendation can be implemented, at least in terms of the network connections, within three months. "Real-time" database-to-database connectivity will take longer because it will require modifications to the underlying systems.

Recommendation #22: Align Medicaid and Title XXI Eligibility Rules

Relevant Issue. As we have noted elsewhere in this report, the most important consumer issue currently facing the Florida KidCare program is maintenance of coverage for a child moving from Medicaid to one of the non-Medicaid Title XXI programs. The greatest opportunity for long-term improvement in the program's operational infrastructure is integration of the DCF and third party administrator eligibility determination systems.

MAXIMUS does not believe that alignment of the Title XXI and Medicaid eligibility guidelines is a pre-requisite for achieving these goals. However, we are convinced that their achievement would be greatly facilitated by bringing all of the KidCare programs under the same eligibility rules.

The Title XXI federal statute stipulates that a state's Medicaid guidelines cannot be changed to shift children from Medicaid to Title XXI. From a practical standpoint in Florida, this means that alignment of the eligibility criteria would have to be in the direction of the Medicaid rules rather than Title XXI parameters. This is because eliminating disregards raises a family's FPL percentage, which inevitably would move some children out of the Medicaid income ranges.

Explanation. MAXIMUS recommends that family size, countable income, and income disregards for each KidCare program be calculated using the Medicaid formulas for three reasons.

First, if the non-Medicaid Title XXI programs adopt the Medicaid eligibility standards, DCF Public Assistance Specialists will be able to assess Title XXI eligibility for any child who is denied Medicaid on the basis of income. With eligibility criteria in alignment, once a family's FPL percentage is calculated, it can be mapped to the age and FPL limits for each KidCare program. This is not possible under the current bifurcated arrangement because a particular Medicaid-based FPL will likely not be the same as the Title XXI-based FPL that arises from the same set of family circumstances. If a PAS can map a family's FPL percentage to all KidCare programs, and if the PAS has the authority to make a definitive Title XXI eligibility determination, then the PAS can arrange a seamless transition between programs by registering the Title XXI determination within FLORIDA for subsequent electronic transmission to CHAS.

Second, integration of the eligibility systems, and the electronic transfer of referrals between systems, will be greatly simplified if both employ the same underlying eligibility algorithms and business rules.

Third, it will be easier to resolve adverse eligibility determination decisions or transitional problems when it is not necessary to explain to a family that Medicaid counts their income or household size differently than MediKids or Healthy Kids. Under the current arrangement, it must surely be difficult for a family to understand, for example, why the income from a child's after-school job is deducted for Medicaid but is counted for Healthy Kids.

Affected entities. DCF, AHCA, CMSN, FHKC, and DHACS (FHKC's third party administrator).

Implementation Timeframe. This recommendation falls into the "Long-Term Opportunity" category because it would have a significant impact on the two eligibility systems, involve the training of PAS staff at DCF, require a state plan amendment, and necessitate the revision of business rules and administrative procedures.

Recommendation #23: Additional Application Changes

Relevant Issue. In studying the KidCare application and soliciting feedback from various stakeholders and partners, we identified several changes that we believe should be considered the next time an Application Workgroup is convened.

Mainly for reasons of space and design, the KidCare application provides few instructions to help a family complete the application correctly and little explanation to provide a context for some of the questions. While the informational brochure is helpful, it fails to address an issue that concerns some immigrant families.

Federal Medicaid and SCHIP guidelines prohibit a state from requiring a SSN for any person listed on an application who is not an intended beneficiary. Florida Medicaid and SCHIP policies conform to this requirement by not making the provision of a parent's SSN a pre-requisite to an eligibility determination. However, the voluntary nature of this

information is not stated on the application and the brochure does not provide a context for why the information is being sought. Recently published federal guidance says that if a SSN is requested from a non-applicant, the voluntary nature of the SSN must be stated, the family must be informed about how the SSN data will be used, and it must be clear that the application will not be denied if the SSN is not provided.

Florida has a sizeable immigrant population. This demographic group presents special challenges, including a fear by some immigrants that applying for children's health insurance may jeopardize their efforts to become U.S. citizens. This fear exists because of the "public charge" policy that adversely links some public aid programs to applications for citizenship. While federal policy expressly forbids that link for Medicaid and state-designed SCHIP programs, some Florida immigrants may be unaware of this and therefore will be reluctant to submit a KidCare application.

Although the KidCare application does not ask for race/ethnicity data, many other states request this information on a voluntary basis to:

- Provide a statistical basis to measure the effectiveness of outreach on particular demographic groups
- Track changes in health status for specific populations
- Aid in the design of consumer surveys that mirror the target population's demographic breakdown

Explanation. While we believe most, if not all, of the changes recommended in this report can be accomplished without a change to the application's size or basic format, we believe the design of the informational brochure may need to be reconsidered.

In weighing other design options, we encourage the Application Workgroup to consider one approach that has worked well in other states: an 8 X 11 booklet with a tear-out application and attached self-addressed envelope. This format provides ample space for instructions, program information, and reasonably large photographs or illustrations to break up the text and enhance the visual appeal. A booklet format would not preclude the use of a legal-size application (assuming a fold near the bottom).

MAXIMUS recommends the following modifications to the KidCare application:

- The word "Optional" should be parenthetically placed underneath or next to the space where the parent's SSN is written.
- For each applicant child, add an "Optional" question for race/ethnicity in the "Child Information" section; to facilitate consistent responses, the application should provide a set of race/ethnicity codes or abbreviations from which to choose.
- Parents' date-of-birth should be retained if it is used to screen for potentially eligible teen parents; it should be removed if it is not intended for that purpose (we were unable to confirm a rationale for having this data item on the application).

Within the brochure (or booklet), MAXIMUS recommends the following additional information or clarifications:

- To comply with the recent federal guidance, a statement is needed informing the family of how a parent's SSN will be used and confirming that the application will not be denied if the SSN is not provided.
- Information about the public charge issue to allay fears that submission of a KidCare application may put at risk any immigrant family's plans to seek U.S. citizenship.
- A sensitively worded context for the solicitation of the health status information (whether in its current single-question format or the revised format as proposed in Recommendation #10).
- An explanation for why the information in the "Day Care" section is requested.
- A brief reminder of the difference between "Social Security" income and "SSI" income.

Affected entities. DCF, DOH (because of the effects of this recommendation on outreach), FHKC, and DHACS (FHKC's third party administrator).

Implementation Timeframe. The application changes can be implemented within six to eight months. However, if modifications to CHAS are also needed to conform to the revised application, a longer implementation timeframe will result.

Recommendation #24: Change How CHAS Generates Correspondence

Relevant Issue. Section III(E) of this report describes how missing application information is identified, solicited and collected. In that section, we note that over a recent six-month period, 16,410 families received multiple missing information letters, many of which were in connection with families that had at least two non-citizen children.

From a programming or systems design standpoint, it may be logical for separate missing information letters to be generated for individual children or in relation to specific missing items. But from a consumer perspective, it must be confusing and bewildering to receive multiple letters from the third party administrator at roughly the same time, each of which is intended to bring an application to a completed stage. From an operational standpoint, multiple letters are wasteful and do not project a completely professional image for the KidCare program.

A bigger problem arises when a family with non-citizen children tries to accelerate the process by including the necessary immigration documentation with the original application. Because CHAS is not currently programmed to anticipate this situation, the family will still receive a missing information letter for each non-citizen child, even though the requested information was already sent. At the least, it will be a frustrating experience to receive follow-up correspondence under these circumstances; at the worst, it will create a sense of alienation that may result in the family simply giving up on the process.

While MAXIMUS appreciates the difficulty of designing a business process that reliably culls applications with immigration documentation for review by suitably trained staff, we believe a better operational approach is available.

Explanation. MAXIMUS recommends several changes to how CHAS handles the task of producing missing information letters:

- A single missing information letter should be sent for all "major errors" rather than separate letters for immigration documentation, missing signature, and all other missing items.
- In the same vein, a single immigration documentation letter should be sent for all non-citizen children within a family (and when other items are missing, those items should also be solicited within a single letter).
- When a family submits immigration documentation with the original application, a missing information letter should not be sent for that purpose.

Affected entities. FHKC and DHACS (FHKC's third party administrator).

Implementation Timeframe. We believe the third party administrator should be able to implement these changes within two to three months.

Recommendation #25: Investigate the Feasibility of Synchronizing the Monthly Processing Schedules for MediKids and Healthy Kids/CMSN

Relevant Issue. MediKids has a different schedule for producing and distributing the monthly enrollment files to the health plans than Healthy Kids and CMSN. Because MediKids operates on the foundation of the regular Medicaid program, its "cut-off dates" are tied to the "Month End Processing" schedule. In comparison, the cut-off date for Healthy Kids and CMSN occurs about a week later to maximize monthly enrollment while still providing the health plans with enough time to meet their processing needs.

This divergence of cut-off dates creates the potential of negative consequences for families with children eligible for both MediKids and Healthy Kids/CMSN. Specifically, it means that, under certain circumstances, a younger child eligible for MediKids will have to wait an additional month for coverage to start compared to the siblings who qualify for Healthy Kids and/or CMSN. This not only means an additional month of risk for the younger child, it also means a decoupling of the six-month continuous eligibility period among the children within a family, which will complicate the renewal process.

Explanation. AHCA, FHKC, and DHACS individually suggested to us a uniform monthly processing date for all non-Medicaid Title XXI programs along with a uniform monthly supplemental file processing date. MAXIMUS agrees that this is a goal worth pursuing.

We believe that AHCA, FHKC, and CMSN should engage in a meaningful dialogue about this issue to determine what changes, if any, can be implemented to mitigate the

problem of young children within a Title XXI-eligible family having different coverage periods from their older siblings.

Affected entities. AHCA, CMSN, FHKC, DHACS (FHKC's third party administrator), and ACS (as the entity holding the AHCA contract).

Implementation Timeframe. A dialogue about this problem could begin virtually immediately. The timeframe for implementation of the consensus decision depends on the complexity of the solution.

Recommendation #26: Establish a Data Link between TEARS and FLORIDA

Relevant Issue. Only one electronic link currently exists between the TEARS system (the Intranet solution that is used to manage and track eligibility determinations for CMSN on the basis of health status) and the other KidCare partners. That is the file transfer (via e-mail attachments) between TEARS and CHAS. The file that is sent on a daily basis from CHAS to TEARS contains records for children who are identified on the application as having special health care needs. The daily file that is sent from TEARS to CHAS contains the disposition of those referrals. CHAS also generates and sends the monthly CMSN enrollment file containing the names of all children who qualify for Title CMSN benefits for the upcoming month.

Because CMSN is a provider network for Medicaid as well as Title XXI, the lack of an electronic interface with DCF makes it difficult for CMSN to identify and track children enrolled in Medicaid who have long-term chronic conditions or disabilities and work with their families to ensure that they receive their benefits through the CMS network rather than a Medicaid HMO or MediPass.

Explanation. MAXIMUS recommends that CMSN technical staff collaborate with their counterparts at DCF to establish an electronic interface between CMSN and the FLORIDA system. This interface, which would function in a manner similar to the CHAS/TEARS interface, would enable DCF to refer to CMSN children who enter the application process through the "Request for Assistance" and for CMSN to send to DCF the disposition of those referrals. To make the best use of the interface, we also recommend that a flag be added to FLORIDA to identify and track CMSN-eligible children.

Affected entities. CMSN and DCF.

Implementation Timeframe. This recommendation can be implemented within six to eight months.

Recommendation #27: Evaluate Optical Character Recognition for Data Entry

Relevant Issue. The layout of the KidCare application, in which parent and child information is captured letter-by-letter in individual boxes, is well suited for reading by Optical Character Recognition (software). When it works well, OCR software is a significant

improvement over manual data entry. When it works poorly, it is counter-productive because the data still has to be manually proofed and corrected as needed.

During our onsite visit to Lisle, DHACS management expressed skepticism about the OCR option because some KidCare applications are received with barely legible handwriting or with writing that goes outside of the prescribed boxes. We agree that if applications are commonly filled out in a way that will be problematic for reading by OCR software, this approach is undesirable. On the other hand, if illegible applications can be identified and set aside for the manual process, while the automated approach is employed to capture the data on the first page of legible applications, significant operational efficiencies could be achieved.

Explanation. MAXIMUS recommends that a DHACS/FHKC workgroup be formed to objectively weigh the relative benefits and risks of moving to an OCR approach for entry of data captured on the first page of the application. This workgroup should focus on the following issues before making a recommendation:

- The proportion of applications that will present serious reliability problems for OCR software
- Application intake procedures that could separate applications into different batches, depending on their likely suitability for OCR data entry (those that are visually deemed suitable for OCR reading would be placed in one batch while the others would be batched separately for handling under the current procedure)
- A cost-benefit analysis focusing on the cost of installing OCR software and related quality assurance business processes compared to the costs associated with the current manual approach

MAXIMUS is not convinced that the use of OCR software as a replacement for manual data entry will be either cost-effective or sufficiently reliable. On the other hand, we are also not convinced that this option should be set aside without further analysis. The format of the application and standardization of the some of the data elements (such as zip codes, SSNs, and addresses) practically invite this analysis.

Affected entities. FHKC and DHACS (FHKC's third party administrator).

Implementation Timeframe. The workgroup could be formed and undertake its analysis very quickly. If the resulting recommendation is to implement or at least pilot-test an OCR solution, we believe this could be accomplished in less than four months.

Recommendation #28: More Systematic Communication Among the KidCare Partners

Relevant Issue. In each of our interviews among the KidCare partners, we asked for feedback about how the partners interacted with one another. A consistent response was that day-to-day coordination and problem solving occurs within a cooperative and productive environment. The personal relationships are amicable and there is a good flow of information and ideas.

However, we also received uniform feedback that "major decisions" or "major communication initiatives" (such as a large-scale mailing or significant media event) sometimes occur without sufficient collaboration and discussion among the partners.

Explanation. MAXIMUS recommends that the KidCare partners agree on a systematic, reliable, and timely communications protocol involving relevant leadership and staff so that major policy changes and communication initiatives occur routinely with the understanding of all the key players. In making this recommendation, we do not anticipate unanimous consent regarding all major issues or initiatives. Rather, we believe that even when disagreements occur, the results will be healthier and more productive if they take place within an environment of open and systematic communication.

Affected entities. FHKC, DCF, AHCA, and DOH.

Implementation Timeframe. Immediate Opportunity.

VIII. Appendix

A. MAXIMUS team

Kari Dingman, Corporate Officer in Charge. With over 13 years experience in Medicaid managed care and SCHIP programs, Mrs. Dingman brings considerable executive-level and hands-on expertise to this project. Her range of knowledge includes project management and implementation, program evaluation, strategic planning, and quality assurance.

Randy Fritz, Project Leader. From 1998 through 2001, Mr. Fritz was the SCHIP Bureau Chief for the Texas Department of Health. In that position, he developed, implemented, and managed all operational aspects of the Texas SCHIP program ("TexCare Partnership"), including procurement and management of 70 contracts worth over $500 million per year. During his time as Bureau Chief, the Texas program enrolled around 450,000 children in its first 18 months of operation.

Teresa Donaldson, Consultant. Ms. Donaldson has over eight years of experience with Medicaid Managed Care in Michigan ("Michigan ENROLLS") and that state's SCHIP program ("MIChild"). In her position as Central Operations Manager, Ms. Donaldson has been directly involved with program design and implementation, personnel management and training, quality assurance, and customer service. She oversees critical operations, including the call center, incoming and outgoing correspondence, employee supervision, and data entry.

Keith Morgan, Consultant. Mr. Morgan directs the MAXIMUS Center for Electronic Government and has more than 20 years of in-depth experience in virtually all aspects of project management and information technology consulting, including mainframe operations, complex distributed systems, and web-enabled solutions. He is a Microsoft Certified Systems Engineer (MCSE – 3.x) and is skilled at solutions design and implementation.

B. Interviews

The following is a list of the interview meetings as well as the individuals who participated. Each meeting included one or more MAXIMUS team-members. In addition, during the main interviews with DCF, AHCA, DOH, and DHACS, Paula Kiger (FHKC Director of Operations) and Lisa Gill (FHKC Director of Programs) also participated. During those meetings, at an appropriate time, Ms. Kiger and Ms. Gill withdrew to facilitate an honest dialogue regarding communication among the KidCare partners.

Meeting with advocates, February 11, 2002

- Virginia Brockman (Sarasota regional outreach)
- Tonya Palmer (Palm Beach County regional outreach)
- Mary Figg (Lawton & Rhea Chiles Center)
- Lucia Maxwell (Executive Director) and Heather Saun (Deputy Director), Panhandle Area Health Network

Meetings with FHKC staff, February 11-12, 2002

- Rose Naff (Executive Director)
- Paula Kiger (Director of Operations)
- Lisa Gill (Director of Programs)
- Merrio Tornillo (Manager of Customer Care Assurance)
- Jennifer Lloyd (Director of External Affairs)
- Samone Hunter (Trainer)
- Bridgett Singleton (Program Integrity Manager)
- Jennifer Betts (Enrollment Manager)
- Frank Fonseca (Eligibility Review Specialist)

Meetings with DCF staff, 2/12

- Linda Ginn (Senior Management Analyst Supervisor)
- Kathy Meade (Economic Self Sufficiency Policy Chief)
- Angela Wiggins (Program Administrator)
- Pat Andrews (Public Assistance Specialist)
- Kim Brock (Bureau Chief for Technologies)

Meeting with AHCA staff, 2/12

- Joyce Raichelson (Program Administrator)
- Peggy Comer (Program Administrator)
- Santiago Sanchez (Program Analyst)
- Deena Watts (Program Analyst)
- Dennis Eskew (Program Analyst)

Meetings with CMSN staff, 2/12

- Phyllis Sloyer (Division Director)
- Danni Atkins (Network Policy and Program Development)
- Jeannette Sanders (Senior Management Analyst)
- Jayne Parker (Executive Community Health Nursing Director)
- Sharyn Bennett, (Nursing Director)

Meetings with DHACS staff, 2/19-20

- Peg Moster (Project Director)
- David Jo (Director of Programming)
- Miguel Mercado (Supervisor of Application and Enrollment)
- Kory Tonnin (Technical Analyst)
- David Frasca (Production Manager)